



australian healthcare &
hospitals association

the voice of public healthcare®



2019–20 PRE-BUDGET

Submission to Treasury

30 January 2019



OUR VISION

A healthy Australia, supported by the best possible healthcare system.

OUR MISSION

To conduct research, educate and influence the healthcare system to achieve better health outcomes, improved patient and provider experience, greater equity and sustainability.

OUR GUIDING PRINCIPLES

Healthcare in Australia should be:

Effective
Accessible
Equitable
Sustainable
Outcomes-focused.

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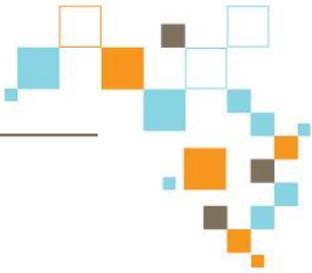


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INTRODUCTION

The Australian Healthcare and Hospitals Association (AHHA) welcomes this opportunity to provide a submission in advance of the 2019–20 Commonwealth Government Budget.

AHHA is Australia’s national peak body for public hospitals and healthcare providers. Our membership includes state and territory health departments, Local Hospital Networks and public hospitals, community health services, Primary Health Networks and primary healthcare providers, aged care providers, universities, individual health professionals and academics. As such, we are uniquely placed to be an independent, national voice for universal high-quality healthcare to benefit the whole community.

Ongoing renewal and reform are features of the Australian health system, driven both by budget pressures and a desire for system improvement, and the need for better patient outcomes. Australians place high value on universal access to a quality health system. To meet this expectation, the 2019–20 Budget must ensure there is continued support for an effective, accessible, equitable and sustainable healthcare system focused on quality outcomes.

The current fee for service funding model in Australia places the focus on throughput of patients rather than sustained, improved health outcomes being achieved. Reorientation of the healthcare system is required to meet contemporary needs and emerging challenges. Maintaining the status quo and tinkering around the edges of system reform will not provide the future-proofed health system that Australians expect and deserve.

This submission outlines a number of areas of reform to the healthcare system that are achievable with leadership by the Commonwealth Government, working in cooperation with state and territory governments and Primary Health Networks. The way our healthcare system is organised needs to be adapted to more effectively delivery healthcare services to improve patient care and to achieve system efficiencies. This submission provides a number of practical and necessary recommendations on how this can be achieved with a broad focus on outcomes, coordination of care and specific areas requiring health policy leadership.

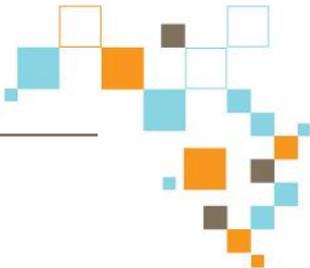
In addition to these recommended funding commitments, AHHA has made extensive recommendations for health reform in a Blueprint which outlines changes required to more effectively deliver healthcare services, improve patient care and achieve system efficiencies. The Blueprint is available at www.ahha.asn.au/Blueprint and addresses four domains for reform: governance, data, funding and workforce.

Health policy should not be determined by economic policy, but rather what is in the best interests of meeting the healthcare needs of all Australians in an economically sustainable manner. The Australian Government recognised the importance the Australian public place on universal healthcare with their initiative announced in the 2017–18 Budget to establish the Medicare Guarantee Fund. The recommendations made in this submission provide the opportunity to build on this expressed commitment to develop a more sustainable, coordinated, accessible and equitable healthcare system.



RECOMMENDATIONS

MOVING FROM VOLUME TO VALUE
Resources and training —\$1.0 million annually for value-based healthcare training, supporting resources, mentoring and communities of practice, contextualised for Australian health services and an Australian audience.
Web-based clearinghouse —\$1.0 million set up, with annual \$300,000 maintenance, to develop, promote and maintain a web-based clearinghouse of quality-assessed evidence on value-based healthcare.
MEDICINES
Improving access to medicines for Aboriginal and Torres Strait Islander people —For states and territories participating in the Public Hospital Pharmaceutical Reforms, allow the Closing the Gap PBS Co-Payment measure to be applied when medicines are dispensed from a public hospital, a re-direction of funds estimated at \$15.1 million. If ACT and NSW were to participate, nationally the re-direction of funds is estimated at \$21.8 million.
Quality Use of Medicines Program —The Australian Commission on Safety and Quality in Health Care be funded to lead development of National Quality Use of Medicines Indicators, to be published consistent with the Australian Atlas of Healthcare Variation, and used to inform investment in the Quality Use of Medicines Grants Program and activity of NPS MedicineWise at the national level, as well as the collaborative activity at jurisdictional and Primary Health Network level.
ORAL HEALTH
National Partnership Agreement funding —\$500 million per year for the <i>National Partnership Agreement on Public Dental Services for Adults</i> , with state and territory funding levels maintained, and the term of the agreement extended to 31 December 2024, aligning with the term of the <i>Child Dental Benefits Schedule</i> . Provision to be made for funding allocations to reflect the cost of providing care in rural and remote areas, smaller jurisdictions and to groups with higher needs.
PRIVATE HEALTH INSURANCE
Productivity Commission inquiry —Funding of \$1.5 million be allocated for a comprehensive Productivity Commission inquiry examining the costs and benefits of private health insurance, including appropriate levels of profitability in the context of annual increases in policy premiums.



HEALTH WORKFORCE
Allied Health Rural Generalist Pathway —\$20.0 million over four years to improve access to allied health services in rural and remote areas, through an allied health rural generalist pathway— including supervisory, managerial and education support in rural and remote health organisations based on local needs assessments.
Aboriginal and Torres Strait Islander community primary healthcare workforce —\$6.0 million to recruit, train and manage Aboriginal and Torres Strait Islander people from local communities as health coaches for one year (\$150,000 each) to intensify the primary healthcare effort to address cardiovascular disease in very remote communities. Thereafter approximately \$100,000 employment and management costs per coach per annum.
HOME CARE PACKAGES
Home care package waiting list —The Commonwealth Government provide extra funding to address the excessive waiting list for home care packages.



MOVING FROM VOLUME TO VALUE

Key recommendations:

- \$1.0 million annually for value-based healthcare training, supporting resources, mentoring and communities of practice, tailored to an Australian audience and context, for Australian health services.
- \$1.0 million set up, with annual \$300,000 maintenance, to develop, promote and maintain an Australian-tailored web-based clearinghouse of quality-assessed evidence on value-based healthcare, with a wide range of resources to support the transition to this new model for funding and delivering better health outcomes.

Opportunity: Consistent with COAG health reforms, AHHA proposes the development of a suite of resources to support the Commonwealth’s stewardship of value-based healthcare, including support for health services to make the transition from current service delivery models to models focused on value.

Context: AHHA has led a substantial body of work on how to transition Australia’s health sector towards value-based, outcomes-focused and patient centred healthcare.^{1,2}

Section 7c of the February 2018 Heads of Agreement on public hospital funding and health reform includes paying for value and outcomes as part of new long-term system-wide reforms agreed for further development by the COAG Health Council. State and territory health departments are currently undertaking work on value-based care, and some programs are currently under way in individual institutions. However, these programs are often impeded by a lack of evidence in the Australian context, and risk being siloed, small scale pilots rather than leading to broad system change—restricting systematic translation and adoption of effective strategies.

RESOURCES AND TRAINING

Proposed work: Value-based healthcare training, supporting resources, mentoring and communities of practice, tailored to an Australian audience and context, focused on four domains:

1. **Enabling value in healthcare**—the change management process to align national and institutional goals, ensure clinician engagement and broader stakeholder buy-in.
2. **Measuring outcomes and costs**—collecting and using data to drive change.
3. **Implementing integrated and patient-focused care**—redesigning care models for value.
4. **Enabling outcomes-based payment approaches**—redesigning funding and payment models for value.

¹ Australian Healthcare and Hospitals Association 2017, *Healthy People, Healthy Systems: Blueprint for a Post-2020 National Health Agreement with Case Study exemplars*, Australian Healthcare and Hospitals Association, viewed 15 January 2019, www.ahha.asn.au/blueprint.

² 42nd IHF World Hospital Congress Redefining Healthcare Workshop—Implementing Value-based Health Care, facilitated by Professor Elizabeth Teisberg, Brisbane, 9 October 2018.



Feedback from Australian participants in international-led training programs is that Australian case studies and methodology need to be developed.³

Commonwealth investment—through the Department of Health and AHHA—could fund the development and roll-out of Australian-tailored value-based healthcare implementation supporting resources and training of executives, policymakers and clinicians.

Pilot programs could inform development of strategies for implementing and adopting value-based, outcomes-focused approaches.

Cost: \$1.0 million annually

WEB-BASED CLEARINGHOUSE

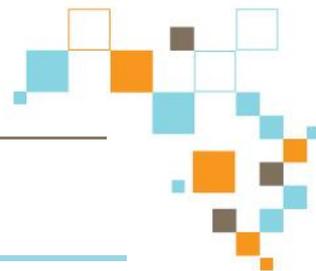
Proposed work: Web-based sharing of quality assessed evidence, for example, case studies, academic and grey literature—specific to and supporting the Australian context—would bring information together in a usable way to support the transition to value-based care.

Feedback from AHHA members and stakeholders is that there is an absence of evidence to inform system design, and that investment in building a repository of evidence, including quality-assessed grey literature, would assist in scaling up small scale trials and projects.

With Commonwealth investment in a web-based clearinghouse of quality-assessed evidence, the Commonwealth Department of Health and AHHA would provide healthcare leaders with a wide range of resources to support the transition to value-based care.

Cost: \$1.0 million set up with annual \$300,000 maintenance

³ Ibid.



MEDICINES

Key recommendations:

- For states and territories participating in the Public Hospital Pharmaceutical Reforms, immediately implement a policy change to allow the Closing the Gap PBS Co-Payment measure to be applied when medicines are dispensed from a public hospital, which would involve a re-direction of funds estimated at \$15.1 million. If ACT and NSW were to participate, nationally the re-direction of funds is estimated to be \$21.8 million.
- The Australian Commission on Safety and Quality in Health Care be funded to lead development of National Quality Use of Medicines Indicators for the community. The measurement of these indicators should then be published consistent with the Australian Atlas of Healthcare Variation and be used to inform the investment in the Quality Use of Medicines Grants Program and activity of NPS MedicineWise at the national level, as well as the collaborative activity at jurisdictional and Primary Health Network (PHN) level.

IMPROVING ACCESS TO MEDICINES FOR ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE

We know that:

- Aboriginal and Torres Strait Islander people are not accessing medicines in the community. Average PBS expenditure per person for Aboriginal and Torres Strait Islander Australians was estimated to be 33% of the amount spent for non-Indigenous Australians in 2013–14, despite higher rates of chronic disease and hospitalisation.⁴
- Patients not taking their medicines after discharge from hospital is a major problem resulting in clinical deterioration, re-hospitalisation and death.
- Acute separations and emergency department attendances present an opportunity to improve access to medicines. In 2016–17, there were 522,000 acute separations⁵ and 503,000 emergency department presentations⁶ for Aboriginal and Torres Strait Islander people.
- All states and territories except NSW and ACT are participating in the Public Hospital Pharmaceutical Reforms, allowing hospitals to prescribe and dispense PBS medicines to

⁴ Australian Health Ministers' Advisory Council (AHMAC) 2017, *Aboriginal and Torres Strait Islander Health Performance Framework 2017 Report*, AHMAC, viewed 29 January 2019
<https://www.pmc.gov.au/sites/default/files/publications/indigenous/hpf-2017/tier3/315.html>.

⁵ Australian Institute of Health and Welfare (AIHW) 2018, *Admitted patient care 2016–17: Australian hospital statistics*, Health services series no. 84. Cat. no. HSE 201, viewed 29 January 2019,
<https://www.aihw.gov.au/getmedia/acee86da-d98e-4286-85a4-52840836706f/aihw-hse-201.pdf.aspx?inline=true>.

⁶ Australian Institute of Health and Welfare (AIHW) 2017, *Emergency department care 2016–17: Australian hospital statistics*, Health services series no. 80. Cat. no. HSE 194. Viewed 29 January 2019,
<https://www.aihw.gov.au/getmedia/981140ee-3957-4d47-9032-18ca89b519b0/aihw-hse-194.pdf.aspx?inline=true>.



outpatients and patients upon discharge. However, the Closing the Gap (CTG) PBS Co-Payment Measure cannot be applied when pharmaceuticals are dispensed from a public hospital.

- A policy change to allow the CTG PBS Co-Payment measure to be applied when medicines are dispensed from a public hospital would improve medicines access by Aboriginal and Torres Strait Islander people living with, or at risk of chronic disease, addressing a range of barriers including cost, transport to community pharmacies and accessibility to community pharmacies once returning to their communities.

It should be noted that:

- Both the cost of the medicine and the cost of the co-payment relief are already incorporated into the current PBS budget as part of the CTG PBS Co-payment Measure.
- A policy change would only realign the location of supply of medicines to patient need, and theoretically should not lead to any additional PBS medicines being dispensed. Rather, it would address the under-utilisation of current CTG support in the community.

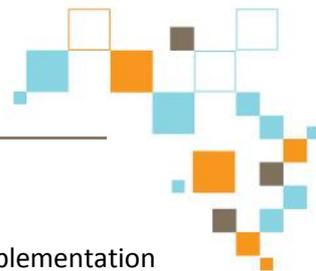
For states and territories participating in the Public Hospital Pharmaceutical Reforms, a policy change could be implemented immediately without renegotiating agreements. **This would involve a re-direction of existing budgeted funds estimated to be \$15.1 million.**

If ACT and NSW were to participate, the total re-direction of funds is estimated to be \$21.8 million.

The funds re-directed to hospitals have been estimated based on hospital presentations by Aboriginal and Torres Strait Islander people and the following estimates for medicines use (based on advice from the Society of Hospital Pharmacists of Australia through members and emergency physicians):

- Acute separation: A complex patient leaving hospital would require on average 6 medicines at discharge. Assuming a concessional patient status, this equates to co-payment re-direction of \$39.00.
- Emergency or same-day acute discharge. A chronic patient leaving emergency or same-day acute discharge would require 3 medicines. Assuming a concessional patient status, this equates to co-payment re-direction of \$19.50.

	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	National	Co-payment re-direction
Emergency department	185,805	32,559	103,095	73,355	23,852	8,168	4,931	71,554	503,319	\$9,663,724
Overnight separations	52,931	11,344	48,770	27,466	10,100	no data	no data	no data	150,611	\$5,783,462
Same-day acute separations	53,032	15,356	78,692	83,417	15,908	2,450	1,459	85,021	335,335	\$6,438,432
TOTAL										\$21,885,619



QUALITY USE OF MEDICINES PROGRAM

The Australian Government's Quality Use of Medicines Program is important in the implementation of and support for the National Strategy for Quality Use of Medicines. It is understood the establishment of NPS MedicineWise in 1997 was funded by the Australian Government, and ongoing funding has been provided through the Program for the services NPS provides, without substantial or independent review.

In order to effectively and independently evaluate the value from the investment in the Quality Use of Medicines Grants Program, AHHA recommends that:

- The Australian Commission on Safety and Quality in Health Care be funded to lead development of National Quality Use of Medicines Indicators for the community (that is beyond Australian hospitals).
- The measurement of these indicators be published consistent with the Australian Atlas of Healthcare Variation and be used to inform the investment in the Quality Use of Medicines Grants Program and activity of NPS MedicineWise at the national level, as well as the collaborative activity at jurisdictional and PHN level.

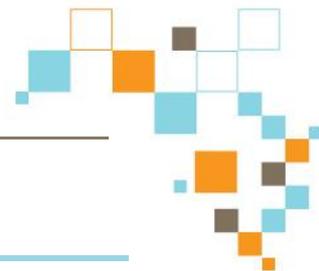
Investment in the approach to quality use of medicines implementation should:

- Be nationally unified and regionally responsive.
- Be evidence informed, and transparently and independently monitored.
- Provide an integrated experience for consumers and clinicians, with consistent messaging in health and healthcare.

Moving forward, funding for the Quality Use of Medicines Program should not be given in a manner that creates segregation or duplication of the roles, expertise and scope of existing entities (e.g. data collection and general practice quality improvement and support by Primary Health Networks (PHNs), the development, analysis and reporting on data by the Australian Institute of Health and Welfare or activities of the Australian Commission on Safety and Quality in Health Care).

Work commissioned by the Australian Government to NPS MedicineWise should be explicitly and formally integrated and coordinated with the work of other entities funded by governments, leveraging expertise held by other entities and minimising inefficiencies and duplication.

PHNs should be instrumental in the implementation of the Quality Use of Medicines Program to address local needs. Plans for implementation at the regional level should be agreed and monitored with the respective PHN, with a transparent understanding of the resources being allocated by NPS MedicineWise. This would support evaluation of investment and impact at the PHN level.



ORAL HEALTH

Key Recommendations:

- \$500 million per year for the *National Partnership Agreement on Public Dental Services for Adults*, with state and territory funding levels maintained, and the term of the agreement extended to 31 December 2024, aligning with the term of the *Child Dental Benefits Schedule*.
- Funding allocations reflect the cost of providing care in rural and remote areas, smaller jurisdictions and to groups with higher needs.
- The agreement must require states and territories to increase access to fluoridated water supplies. Fluoride varnish programs should be provided to high risk children, particularly in non-fluoridated areas.
- Actively promote the *Child Dental Benefits Schedule* to eligible families.
- Incorporate oral health assessments into health assessment frameworks, particularly those at risk, for example children and older people.
- Appoint an Australian Chief Dental Officer to provide national coordination of oral health policy.

Oral health is fundamental to overall health, wellbeing and quality of life. A healthy mouth enables people to eat, speak and socialise without pain, discomfort or embarrassment.

Australia's National Oral Health Plan 2015–2024 outlines a blueprint for united action across jurisdictions and sectors to ensure all Australians have healthy mouths. Translation of the National Oral Health Plan into practice has been slow, and requires all jurisdictions and sectors to work together to maintain and improve the oral health of Australians.

Despite improvements over the last 20–30 years, there is still evidence of poor oral health among Australians⁷:

- More than 90% of adults and 40% of young children have experienced tooth decay at some stage in their life.
- 30% of adults have untreated tooth decay.
- Only 40% of Australian adults have a favourable visiting pattern, i.e. seeing a dentist once a year for a check-up, rather than waiting to treat poor oral health.
- Oral conditions are the third highest reason for acute preventable hospital admissions with more than 63,000 Australians hospitalised each year.
- Out-of-pocket costs for dental care are greater than any other major category of health spending, having greatest impact on those eligible for public dental services.

⁷ Australian Institute of Health and Welfare (AIHW) 2018, *Oral health and dental care in Australia*, viewed 23 January 2019, <https://www.aihw.gov.au/reports-data/health-conditions-disability-deaths/dental-oral-health/overview>.



Inequities in oral health outcomes continue to persist:

- Aboriginal and Torres Strait Islander people and adults who are socially disadvantaged or on low incomes have more than double the rate of poor oral health than their counterparts.
- People with additional or specialised healthcare needs and those living in regional and remote areas have more difficulty accessing oral healthcare.
- Nearly 3 million Australians, more than 11% of the Australian population, do not have a fluoridated water supply.

PUBLIC DENTAL TREATMENT

Budget 2014–15 cut \$650 million from dental programs across the forward estimates, in addition to expenditure cuts of \$42.4 million made in the Mid-Year Economic and Fiscal Outlook 2013–14⁸. In Budget 2015–16, further measures relating to dental health were introduced with a reduction in expenditure of \$125.6 million across the forward estimates from the Child Dental Benefits Schedule (CDBS), in addition to reduced expenditure on dental workforce programs and payments to Department of Veterans' Affairs dental health providers. This Budget also removed funding in the forward estimates for adult public dental services⁹.

On 15 December 2016, the then Minister for Health and Aged Care announced funding cuts for public dental services as of 1 January 2017. While the Minister announced the National Partnership Agreement for public dental services to adults would continue to receive federal funding of \$320 million in 2017–19 (or less than \$107 million per year for the next three years)¹⁰, this resulted in a reduction from the former Minister's announcement of about \$155 million in calendar year 2016. The original Budget measure in 2013–14 allocated \$391 million in 2016–17.

The 2018–19 Mid-Year Economic and Fiscal Outlook announced a one year extension on the National Partnership Agreement on Public Dental Services for Adults at a cost of \$107.8 million.

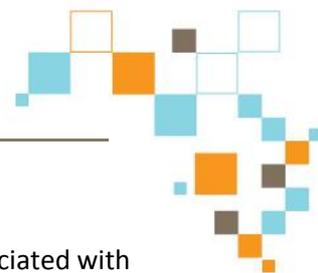
The Government's decision to reduce federal funding to the states and territories for the provision of essential dental services to the most vulnerable in the community means that wait times at public dental clinics, which are already running into years, will only get longer and leave more patients at risk of deteriorating health outcomes and in need of costly remedial treatment in public hospitals. These changes will negatively impact Australians least able to afford proper dental care.

Funding of \$500 million per year is needed for the National Partnership Agreement for public dental services with state and territory government funding levels maintained to improve access to and affordability of dental care, and address inequities in oral health.

⁸ Russell, L 2014, *Analysis of 2014-15 Health Budget: Unfair and Unhealthy*, Menzies Centre for Health Policy, University of Sydney, Sydney.

⁹ Commonwealth of Australia (CoA) 2015, *Budget 2016-2017: Budget Paper No. 2*, Commonwealth of Australia, Canberra, viewed 13 November 2017, <https://www.budget.gov.au/2016-17/content/bp2/html/>.

¹⁰ Ley, S 2016, *Continued funding for states from 1 January 2017*, Minister for Health and Aged Care, 15 December 2016, viewed 25 January 2019, [http://www.health.gov.au/internet/ministers/publishing.nsf/Content/DDA645B010401EB7CA25808A000BA829/\\$File/SL108.pdf](http://www.health.gov.au/internet/ministers/publishing.nsf/Content/DDA645B010401EB7CA25808A000BA829/$File/SL108.pdf).



PREVENTION

There is consistent evidence that water fluoridation at current Australian levels is associated with decreased occurrence and severity of tooth decay in children, adolescents and adults¹¹. Nearly 3 million Australians, more than 11% of the Australian population, do not have a fluoridated water supply¹².

The Commonwealth should provide national leadership by working with state and territory governments to ensure fluoridation of all reticulated water supplies in Australia. AHHA also supports a linkage between Commonwealth funding of dental services and the extent of state and territory water fluoridation programs.

BARRIERS TO TREATMENT

Out-of-pocket cost to individuals is acknowledged as a major barrier to appropriate and regular dental healthcare. In Australia in 2016–17 payment for dental services is primarily borne by individuals with 57.7% of national dental expenditure. Health funds paid 18.7%, the Commonwealth's direct outlay was 8.0% with an additional 6.9% for health insurance premium rebates and 8.2% from state and territory governments¹³.

The out-of-pocket cost barrier has a differential effect upon whether people attend a dentist, have the treatment they need and feel the financial burden of dental treatment costs. More than 30% report that they avoid or delay visiting a dentist due to cost¹⁴. Those in lower household income groups had higher rates of avoiding or delaying a visit to a dentist due to cost than those in higher income groups. Access to dental practitioners is also a barrier to dental care, particularly for those Australians living in rural and remote Australia. Capital cities have nearly 2.5 times more dental practitioners per person than remote areas¹⁵. In small towns this widened, despite improved national averages, since 1981¹⁶.

AHHA recommends that the Commonwealth better promote the CDBS to the families of eligible children. Better reporting and analysis of CDBS data will also provide stronger evidence for the effectiveness of this program, as well as identifying opportunities to target care for vulnerable groups and those living in geographical areas with limited access to dental services.

¹¹ NHMRC 2017, *Water fluoridation: dental and other human health outcomes*, National Health and Medical Research Council, Canberra. Viewed 25 January 2019, <https://nhmrc.gov.au/about-us/publications/water-fluoridation-dental-and-other-human-health-outcomes>.

¹² Australian Bureau of Statistics (ABS) 2017, *3101.0 - Australian Demographic Statistics, March 2017*, Commonwealth of Australia, Canberra, viewed 25 January 2019, <http://www.abs.gov.au/ausstats/abs@.nsf/mf/3101.0>.

¹³ Australian Institute of Health and Welfare (AIHW) 2018, *Health expenditure Australia 2016–17*, viewed 23 January 2019, <https://www.aihw.gov.au/reports/health-welfare-expenditure/health-expenditure-australia-2016-17/contents/table-of-contents>.

¹⁴ Chrisopoulos, S, Harford, JE and Ellershaw, A 2016, *Oral health and dental care in Australia: key facts and figures 2015*, Australian Institute of Health and Welfare, Canberra.

¹⁵ Australian Institute of Health and Welfare (AIHW) 2016, *Oral health and dental care in Australia: key facts and figures 2015*, Cat. no. DEN 229. Canberra: AIHW.

¹⁶ Bourne K, Nash A, and Houghton, K 2017, *Pillars of communities: Service delivery professionals in small Australian towns 1981 – 2011*, The Regional Australia Institute.



PRIVATE HEALTH INSURANCE

Key recommendation:

- Funding of \$1.5 million be allocated for a comprehensive Productivity Commission inquiry examining the costs and benefits of private health insurance within the overall health sector, including appropriate levels of profitability in the context of annual increases in policy premiums.

The Australian health system and its model of universal healthcare are complex—with public and private providers, public and private sources of funding, and concepts of patient choice and equity of access, clinicians as business owners and as employees, sitting side by side. Changes to that system, such as potentially limiting the use of private health insurance in public hospitals, need to be made with care as there are many possible consequences including: funding pressures for public hospitals; difficulties with recruiting and retaining clinicians; reducing choice for patients whose preferred clinician may also prefer to practise in a public hospital; and decreasing the value proposition for private health insurance where private hospital services may not be available. These issues should be examined as part of an overall review of health system funding in Australia—to ensure that we maintain a strong universal health system with care available and affordable for all who need it, not just those who can afford it.

With more than \$6.15 billion of public money given to private health insurers through the private health insurance rebate in 2018–19, and only half of Australians having private health insurance coverage, the Commonwealth Government should establish a comprehensive Productivity Commission inquiry to examine the costs and benefits of private health insurance within the overall health sector. The Productivity Commission inquiry should also consider whether private health insurers, whose products are subsidised by the Government, should be required to provide health data to government agencies such as the Australian Institute for Health and Welfare. In addition, this inquiry should investigate the appropriate level of risk adjusted returns and management expense ratios, and associated annual premium increases, within the private health insurance industry. This should explicitly include recognition that a large proportion of industry revenues are significantly de-risked through Government policies including the Australian Government Rebate on private health insurance, the Medicare levy surcharge, Lifetime Health Cover and premium discounts for 18 to 29 year olds.



HEALTH WORKFORCE

Key recommendations:

- \$20.0 million over four years to improve access to allied health services in rural and remote areas, through an Allied Health Rural Generalist Pathway—including supervisory, managerial and education support in rural and remote health organisations based on local needs assessments.
- \$6.0 million to recruit, train and manage Aboriginal and Torres Strait Islander people from local communities as health coaches for one year (\$150,000 each) to intensify the primary healthcare effort in very remote communities. Thereafter approximately \$100,000 employment and management costs per coach per annum.

ALLIED HEALTH RURAL GENERALIST PATHWAY

Opportunity: AHHA proposes that the Commonwealth demonstrate its commitment to rural health through support for equitable access to allied health services in rural and remote areas.

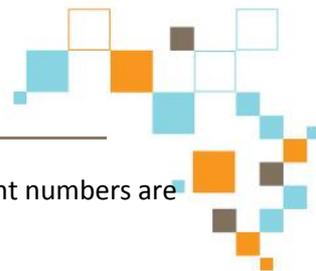
Context: To address issues of health practitioner recruitment, retention, and quality and safety in isolated areas, early career allied health professionals need to be supported to embrace career development opportunities in those areas—not just through working to their full scope of practice, but through participation in planning, developing and implementing rural health service delivery models, embedding themselves in multidisciplinary teams and collaborating across the health system to meet community needs.

Implementing and embedding Queensland’s Allied Health Rural Generalist (AHRG) Pathway nationally through a multi-jurisdictional partnership will build the capacity, value and sustainability of allied health services and multidisciplinary teams in rural and remote areas. Initial support is required for the following Pathway components:

1. **Service models** that address the challenges of providing the broad range of healthcare needs of rural and remote communities.
2. **Workforce and employment structures** that support the development of rural generalist practice capabilities through supervision and education.
3. **An education program** tailored to the needs of rural generalist allied health practitioners, building on work led by AHHA on behalf of Queensland Health, and overseen by a multi-jurisdictional partnership, to develop an accreditation system to support the AHRG Pathway.

Proposed work: AHHA members and stakeholders have identified the need for initial support in implementing and embedding the Pathway in a sustainable manner through:

- Building on existing structures to support funders, commissioners and service providers to implement cross-sector Primary Health Network/Local Hospital Network partnerships. Access to allied health services will be enabled by responding to local needs assessments through: regional governance models (clinical and business); supervisory, managerial and education support; and strategies for pooling funds.



- Quality assurance of education programs, with subsidies provided only until student numbers are sufficient for a self-sustaining system.
- Recognising the needs of individuals working across sectors and disciplines in rural and remote areas; and expanding the Pathway to support all allied health professions and support workers as well as to the disability and aged care sectors.

Cost: \$20.0 million over four years

IMPROVING ABORIGINAL AND TORRES STRAIT ISLANDER CARDIOVASCULAR HEALTH

Opportunity: The intended outcome is reduced mortality and morbidity from cardiovascular disease (CVD) in very remote Aboriginal and Torres Strait Islander communities, with additional benefits including improved healthcare, community development, local employment and skills training. The project could also be extended to include mental health first aid, diabetes and rheumatic heart disease.

Context: CVD, the major cause of early death for Aboriginal and Torres Strait Islander people, is responsible for one-third of the gap in life expectancy compared with non-Indigenous Australians. In remote communities CVD is not managed effectively in primary healthcare and Aboriginal and Torres Strait Islander people have higher CVD rates than non-remote communities.

INTENSIVE PRIMARY HEALTHCARE COACHES

Proposed work: The project will use locally recruited, trained and managed Aboriginal or Torres Strait Islander people as health coaches to intensify primary healthcare efforts in very remote communities, targeting the health needs of approximately 20,000 people. An initial group of 40 health coaches will be employed within their local community health centre, Aboriginal Medical Service (AMS) or Aboriginal Community Controlled Health Organisation (ACCHO) following training, using a micro-credentialing approach, within the Aboriginal and Torres Strait Islander Health Workers training pathway. They will intensively support patient compliance with primary healthcare treatments/recommendations to reduce CVD risk through better management of high blood pressure and blood lipids.

Who does it involve? Development and delivery of the training pathways, supervision, mentorship and management of the Aboriginal or Torres Strait Islander health coaches, including program evaluation, will require a co-design approach. This would involve a training package development organisation, Primary Health Networks (PHNs), the National Aboriginal and Torres Strait Islander Health Workers Association (NATSIHWA), health researchers, relevant state and territory NACCHO affiliates, vocational education and training providers, and state and territory health departments. At a minimum, a partnership consisting of NATSIHWA, AHHA, a PHN and relevant NACCHO affiliate, will be required. AHHA will provide advocacy and coordination for the partnership, in addition to project evaluation.

Cost: \$6.0 million for training and employment of up to 40 Aboriginal and Torres Strait Islander health coaches for one year (\$150,000 each). Thereafter approximately \$100,000 employment and management costs per coach per annum.

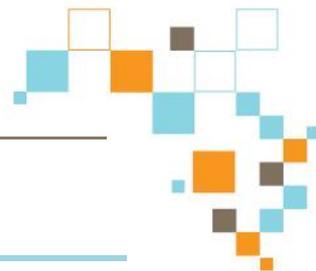


Additional funding will be required to expand coverage beyond very remote communities. This project may be eligible for support from the Health Innovation Fund, Integrated Team Care funding and for eligible organisations, the Indigenous Remote Service Delivery Traineeship Program.

Is there policy alignment? A health coaching approach is strongly aligned with the principles and priorities of regional and national policies, including the National Aboriginal and Torres Strait Islander Health Implementation Plan, National Safety and Quality Health Service Standard 2 (Partnering with Consumers) and the National Strategic Framework for Chronic Conditions.

Are there additional benefits? Additional project benefits include entry into a recognised training pathway, entry-level employment opportunities in local communities where unemployment is high, improved sustainability by using local people who are more likely to stay in their community, as well as utilisation of their superior language skills, local knowledge and community relationships.

What is the evidence? There is good evidence to support this approach. Intensive primary healthcare support has demonstrated success in reducing the biomedical risk factors for cardiovascular disease, high blood pressure and abnormal blood lipids, in remote Aboriginal communities. In addition, basic primary healthcare delivered by health workers produces good clinical outcomes for patients with diabetes. Basic primary healthcare can also reduce risk factors for rheumatic heart disease.



HOME CARE PACKAGES

Key recommendation:

- The Commonwealth Government provide extra funding for home care packages noting the funding for 10,000 extra packages announced on 8 January 2019 does not fully address the home care package waiting list.

Every older person should be able to live well, with dignity and independence, as part of their community and in a place of their choosing, with a choice of appropriate and affordable support and care services when they are needed. Aged care services must be high quality and responsive to the diversity of need, with independent monitoring, transparent public reporting and accountability upheld.

A ten-year reform plan was released in 2012 to create a sustainable, consumer-driven and market-based aged care system:

- My Aged Care was introduced as a central gateway for accessing Australian Government subsidised aged care services.
- Home care packages were introduced, providing services between the Commonwealth Home Support Program (CHSP) and residential aged care.

However, access to care is still a problem for a significant number of older Australians. The number of people waiting for home care packages is far greater than the number of people receiving care at their approved level. Waiting times for home care packages are long (27% have waited more than 12 months since being approved¹⁷). Data sources to accurately determine unmet demand in the community are lacking.

On 8 January 2019 the Minister for Senior Australians and Aged Care announced the rollout of an additional 10,000 new high-level home care packages as part of the Commonwealth's aged care funding increase, announced in December 2018. However this does not fully address the home care package waiting list.

All of the additional 5,000 Level 3 and 5,000 Level 4 packages are to be allocated by 30 June 2019, providing funding for up to \$50,000 of care services per person per year including nursing, home assistance, transport support, nutrition and meal preparation.

The Commonwealth's own data indicates a waiting period of more than 12 months for Level 2, 3 and 4 home care packages, and a three to six month waiting period for Level 1 packages.¹⁸ This must be addressed in the interests of ensuring quality of life for older Australians.

¹⁷ Commonwealth Department of Health 2018, *Home Care Packages Program Data Report 2nd Quarter 2017-18*, viewed 25 January 2019, https://www.gen-agedcaredata.gov.au/www_ahwgen/media/Home_care_report/HCP-Data-Report-2017%E2%80%932nd-Qtr.pdf.

¹⁸ Commonwealth of Australia, myagedcare, *Receive the outcome of your assessment*, viewed 25 January 2019, <https://www.myagedcare.gov.au/help-home/home-care-packages/accessing-home-care-package>.

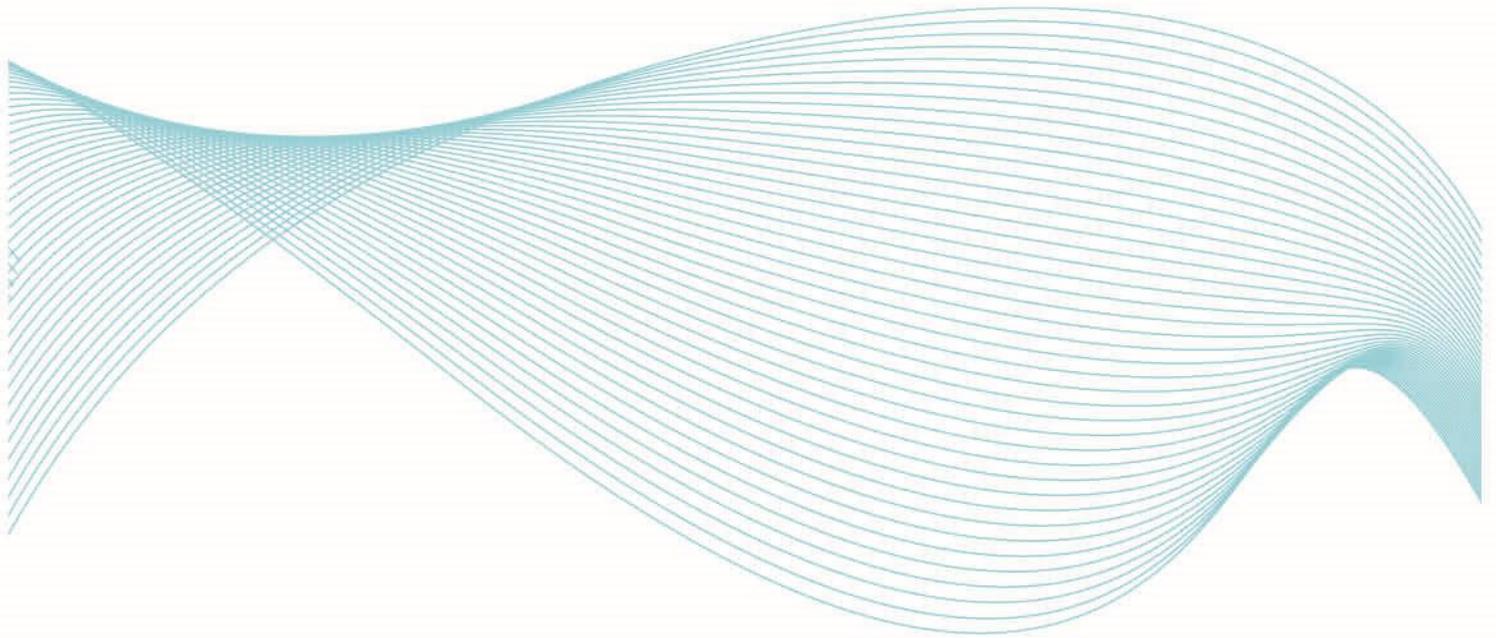


CONCLUSION

This submission outlines a number of areas of reform to the healthcare system that are achievable with appropriate funding and leadership by the Commonwealth Government, working in cooperation with state and territory governments and Primary Health Networks. In addition to these recommended funding commitments, AHHA has made extensive recommendations for health reform in a Blueprint which outlines changes required to more effectively deliver healthcare services, improve patient care and achieve system efficiencies. The Blueprint is available at www.ahha.asn.au/Blueprint and addresses four domains for health system reform: governance, data, funding and workforce.

The Australian Government recognised the importance the Australian public place on universal healthcare with their initiatives announced in the 2017–18 Budget to establish the Medicare Guarantee Fund. The recommendations made in this submission provide the opportunity to build on this expressed commitment and recognise community desire for a more sustainable, coordinated, accessible and fair healthcare system.

Together with this submission, the AHHA Blueprint for health reform provides a number of practical and necessary strategies for reform with a broad focus on outcomes, coordination of care and specific areas requiring health policy leadership. If fully implemented, these proposals present a comprehensive set of meaningful reforms that are based on a staged, strategic and cooperative approach to the reform of the Australian healthcare system.



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