Pre-Budget Submission to Treasury 2016-17

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Australian Healthcare and Hospitals Association
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INTRODUCTION

The Australian Healthcare and Hospitals Association (AHHA) welcomes this opportunity to provide a submission in advance of the 2016-17 Australian Government Budget.

The AHHA is Australia's national peak body for public hospitals and health care providers. Our membership includes state 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.

Much of the recent focus for health policy discourse in Australia has been on economics and funding, and the importance of building sustainability into the Australian healthcare system. The economics of healthcare and a healthy population contributing to the economy underpinned the establishment of Medicare over 30 years ago, and it is timely that the Australian community should refocus on ensuring Medicare retains the capacity to support accessible universal healthcare for all Australians into the future.

While the AHHA agrees that it is incumbent on the Government to ensure that tax payers are getting value out of the money invested into healthcare, it is also essential that reform of the health system is evidence-based, developed in consultation with consumers, clinicians and service representatives, considers the implications and impacts across the whole health system and is implemented and evaluated through a structured and considered approach. The AHHA recognises the Government's commitment to fiscal repair, but it is also imperative that short-term measures do not have long reaching adverse consequences for the health of Australians. It is vital that health policy not be merely viewed through the prism of budgetary cycles. In the field of healthcare, imprudent savings made in the current budget cycle can manifest in poorer individual health outcomes and an increased burden on the healthcare system in the future.

With the range of review and reform processes currently underway, there is the unique opportunity to achieve equitable, balanced and forward thinking reform both within and across the primary, acute, aged and disability care sectors. Equitable in ensuring that all Australians are able to access the health care they need and without unreasonable financial penalty. Balanced in recognising the inherent linkages across our healthcare system and the need to provide sustainable funds to enable the delivery of these services. Forward thinking in recognising that healthcare is an investment in the future well-being and productivity of all Australians.

The most recent healthcare expenditure data shows some revealing statistics on growth in healthcare spending and how this financial burden is spread across the community. In 2013-14 Australian Government health expenditure rose in real terms by 2.4 per cent over the year and was 0.1 per cent less than in 2011-12. Individuals' share of health expenditure, however, saw a real increase of 3.2 per cent in 2013-14 following a 7.2 per cent increase in 2012-13. Over the five year period to 2013-14, spending by the Commonwealth on health expenditure grew in real terms by 2.8 per cent, but for individuals by 6.5 per cent.[1]

While health expenditure has increased as a proportion of total government tax revenue, this is a reflection of reduced tax revenue as much as increased expenditure. The AHHA maintains that concerns over the level of health expenditure must not be viewed in the context of cyclical variations in the economy. Just as the Government asks the Australian public to accept their fiscal strategy over the long term, so too must the Australian health system be funded with a view to the long term benefits of a well-functioning and funded healthcare system.

Most of the recommended budget measures and policy directions that we present below do not seek new or additional funding, but rather to more sensibly target and organise the existing health infrastructure Australia already has in place. It is in this context that the AHHA provides its pre-Budget submission which focusses on the identification of measures to support the sustainability of Medicare and the broader health system in Australia through mechanisms that focus on patient equity, system efficiency and quality of patient care. They also emphasise the need for better coordination across primary, acute, aged and disability care sectors with both the efficiencies and better patient outcomes this can produce.

[1] Australian Institute of Health and Welfare (AIHW). 2015. Health expenditure Australia 2013-14. Health and welfare expenditure series no. 54. Cat. no. HWE 63. Canberra: AIHW.

Summary of Recommendations

Policy Area	Government Action Required
Reform of the Healthcare Sector	Any reform of the healthcare and related systems must be considered as part of a co-ordinated approach to the delivery of care across the primary, acute, aged and disability care sectors. No further cuts to health expenditure spending should be made until current review processes are completed. Estimated cost: Within existing resources.
System Integration	The Government must ensure that ehealth tools and resources are at the forefront of any system change. Primary Health Networks should have adequate, long-term funding to carry out their core functions, with flexible funding to meet community needs. Estimated cost: Within existing resources.
Interface Between Health, Aged Care and Disability Services	The Government should take action to align the interfaces between health, aged care and disability services. Estimated cost: Within existing resources.
Lighthouse Hospital Project	The Government provide funding for Phase Three of the Lighthouse Hospital Project to improve the treatment of acute coronary syndrome conditions among Aboriginal and Torres Strait Islander people. Estimated cost: $17.0 million over five years.
Better Use of Medicines and Treatments	Continue the Medicare Benefits Schedule Review currently underway, and link in with work separately being undertaken by the Commonwealth funded National Prescribing Service (NPS) on the Choosing Wisely initiative. Estimated cost: Within existing resources. Ensure alignment of NPS work in promoting evidence-based use of medicines and treatments with the Primary Health Network roles in developing regional health pathways and supporting capability development in general practice. Estimated cost: Within existing resources.

Oral Health	The Government should extend eligibility for public dental services beyond concession card holders to lower income Australians. A performance and reporting structure focusing on outcomes rather than throughput should be developed. Estimated cost: $1.0 million. Appoint an Australian Chief Dental Officer to coordinate oral health policy. Estimated cost: $0.5 million per annum.
Pharmaceuticals and Pharmacy	Reform in the pharmaceutical and pharmacy sector must be considered as part of a coordinated approach to achieving the objectives of the National Medicines Policy.
Preventive Healthcare	The Government must prioritise developing and implementing preventive health strategies.
End of Life Planning	End of life care plans should be incorporated into aged care and My Health Record personal electronic records. Estimate cost: Within existing resources. An MBS item to support the central involvement of GPs in end of life planning. End of life planning is made part of the accreditation and quality framework. Estimate cost: Within existing resources.
Social Impact Investing	The Commonwealth Government should work with state and territory health departments to pilot small scale social impact investing initiatives tied with research components to establish an Australian evidence base on the effectiveness of this novel financing model. Estimate cost: Within existing resources.
Hospital Benefit	If a Hospital Benefit is introduced, then the price of each item must be independently set and there must be a reasonable level of certainty around the ongoing share of funding responsibilities. Estimated cost: Subject to negotiations between the Commonwealth, State and Territory Governments.

1. Coordinated Response to Reform of the Healthcare Sector

Key Recommendations:
- Any reform to the healthcare and related systems must be considered as part of a co-ordinated approach to the delivery of care across the primary, acute, aged and disability care sectors.
- No further cuts to health expenditure spending should be made until current review processes are completed.

The Government currently has a number of review processes underway that will impact on different parts of the health system in potentially far reaching ways. The more prominent of these include:

- Review of the Medicare Benefits Schedule
- The Primary Health Care Advisory Group
- Consultations on private health insurance
- Reform of the Federation
- Reform of the Australian tax system

The Government has also recently announced coordinated packages of care for mental health services, and the National Disability Insurance Scheme is being progressively rolled out across most of Australia from July 2016.

It is vital that any reforms to come from these processes are considered as part of a co-ordinated approach to the delivery of care across the primary, acute, aged and disability care sectors. This should be with the aim of improved health outcomes, in addition to achieving efficiencies and other innovations with the delivery of services both within and across sectors.

Many of the inefficiencies within the healthcare system have arisen due to continual incremental change implemented in isolation and often with narrowly defined goals. But the healthcare system comprises a complex set of processes and contact points with non-constant interrelationships. How an individual interacts with the healthcare system also changes over time as their own health needs change. How services are funded can also influence system performance and patient outcomes.

The opportunity for meaningful health system reform available to the Government at this stage of comprehensive internal review should therefore not be compromised by any Budget decision that effectively pre-empts these review processes. The danger this would represent is more incremental change that may address one policy objective while unintentionally compromising others. The AHHA calls on the Government to not make any further cuts to health spending until the findings and recommendations from these processes are known and can be holistically considered.

2. Commonwealth Leadership on System Integration

Key Recommendations:
- The Government must ensure that ehealth tools and resources are at the forefront of any system change.
- Primary Health Networks should have adequate, long-term funding to carry out their core functions, with flexible funding to meet community needs.

The AHHA acknowledges the Commonwealth Government's continued support for the national implementation of ehealth tools and resources as holding immense potential to support high quality and consistent care, as well as supporting a number of efficiencies and reduction of waste. The benefit and value of standardised use of electronic health records (EHRs) are well documented: better information sharing and communication between healthcare providers and between patient and provider; reduced duplication or over-servicing; more efficient and more appropriate treatments; and EHRs respond to the needs of both clinicians and consumers by being portable and transferrable. They also stand to better support prescribing and referrals for tests and other procedures and would align with other efforts to reduce inappropriate or unnecessary testing and medication prescription.

Greater use and entrenchment of personal electronic health records would:
- Further integrate and support appropriate care regardless of the point of access in the system.
- Provide a greater focus on a digital healthcare system, which would also support better performance reporting.
- Enhance the capability to allow for performance reporting in real time and across a community through linked data collected and analysis to support quality service provision, achievement of health outcomes and responsiveness in delivery programs and services that meet identified needs.
- Allow for information sharing across health services, both public and private, enabling governments and other funders to identify better utilisation of resources for health.

The establishment of Primary Health Networks (PHNs) provides the opportunity for strong Commonwealth leadership to establish primary health care as the cornerstone of an innovative, responsive and strong health system. It is vitally important that PHNs are provided with adequate long-term funding and supports to establish themselves, with flexible funding to meet the needs of their communities and develop innovative solutions to promote better health outcomes.

Insufficient and uncoordinated primary care services inevitably lead to increased demand on acute hospitals through outpatient clinics, emergency departments and hospital admissions. Funding arrangements should reflect the nature of community needs and should allow for facilitating the right care in the most appropriate environment.

3. Improving the Interface Between Health, Aged Care and Disability Services

Key Recommendation:
- The Government should take action to align the interfaces between health, aged care and disability services.

The AHHA recommends that the Government initiate action to align the interfaces between the health, aged care and disability services. These interfaces should be consumer-centred with integrated care being the shared goal of each of these sectors. This process must ensure that all sectors impacted are appropriately represented, with leadership from the relevant sector in partnership with the aged care sector.

While integration issues within the healthcare system often focus on interactions between primary care sector and hospitals, it is also vital to address coordinated care issues as they relate to the people being cared for within the aged care sector. With an ageing population, effective provision of care and managing transitions in care are increasingly important.

Elements that should be considered as part of this process include:
- Better evidence on the transitions between community and residential aged care and hospitals. This could be affected by the Australian Institute of Health and Welfare (AIHW) being tasked with updating the most recent (2008-09) report on transitions between hospitals and aged care.[2]
- Better collection and use of data across health and aged care, including connection of the My Health Record and the My Aged Care Gateway.
- Better workforce planning, including setting of remuneration levels across aged care and health sectors.
- Better MBS funding via incentive arrangements for provision of medical services in aged care facilities, to assist in ensuring GP services are available in aged care and reduce preventable hospitalisations.
- Better management of discharge arrangements from hospitals to aged care facilities.

This review should include consumers, Primary Health Networks, GP Liaison Officers in hospitals, hospitals, social workers, assessment teams and aged care facilities.

[2] AIHW. 2013. Movement between hospital and residential aged care 2008-09. Data linkage series 16. Cat. no. CSI 16. Canberra: AIHW.

4. Support for the Lighthouse Hospital Project

Key Recommendation:
- The Government provide funding of $17.0 million over five years for Phase Three of the Lighthouse Hospital Project to improve the treatment of acute coronary syndrome conditions among Aboriginal and Torres Strait Islander people.

The Lighthouse Hospital Project is jointly conducted by the Heart Foundation and the AHHA. Phase 1 of the project aimed to identify and document case studies that highlighted best practice in the care of Aboriginal and Torres Strait Islander people experiencing heart attack. Due to the paucity of empirical evidence on heart attack treatment models in the literature, an industry-based quality matrix was developed that could be incorporated into hospital accreditation processes, enabling the setting of care standards, including agreed performance indicators and monitoring processes, and overall enabled a commitment to quality improvement of care. This was then trialled in eight hospitals across Australia in Phase 2 of the project that has funding remaining until 1 June 2016.

The AHHA recommends that the Government provide funding to enable Phase 3 of the Lighthouse Hospital Project to proceed. This will require funding of $17.0 million over five years. Phase 3 will extend the trial of this innovative care to 24 hospitals across Australia.

Coronary heart disease (CHD) is the leading cause of death among Aboriginal and Torres Strait Islander people. Compared to non-Indigenous Australians, Aboriginal and Torres Strait Islander people are 60 per cent more likely to die to from CHD and it is responsible for one in every seven deaths among Aboriginal and Torres Strait Islander people.[3] While Aboriginal and Torres Strait Islander people are more likely to die from CHD, those aged 35 to 54 are at least six times more likely to die than non-Indigenous Australians.[4]

CHD is also the leading cause of morbidity and disability. The disease develops at younger ages and progresses faster than in non-Indigenous Australians. The burden of CHD among Indigenous people is also reflected in hospital admissions. Aboriginal and Torres Strait Islander people have a higher likelihood of being admitted to hospital for an acute coronary syndrome (heart attack and unstable angina). They are more likely to die in hospital or to leave hospital against medical advice. While in hospital with a diagnosis of CHD, Aboriginal and Torres Strait Islander Australians are less likely than non-Aboriginal and Torres Strait Islander Australians to undergo a coronary procedure.

An application for the funding of Phase 3 of the Lighthouse Project has been submitted to the Department of Health. This will build on the success of Phase 2 and aims to drive efficiency and change within the health system to improve health outcomes by delivering health care that is evidence based, clinically accurate, culturally safe, responsive and accessible for Aboriginal and Torres Strait Islander people experiencing heart attack.

[3] AIHW. 2014. Mortality and Life Expectancy of Indigenous Australians, 2008-2012. Cat No. IHW 140.
[4] AIHW. Premature mortality in Australia 1997-2012. Supplementary data tables. Canberra:AIHW (available at http://www.aihw.gov.au/deaths/premature-mortality/source-data/).

5. Better Use of Medicines and Treatments

Key Recommendations:
- Continue the Medicare Benefits Schedule Review currently underway, and link in with work separately being undertaken by the Commonwealth funded National Prescribing Service (NPS) on the Choosing Wisely initiative.
- Ensure alignment of NPS work in promoting evidence-based use of medicines and treatments with the Primary Health Network roles in developing regional health pathways and supporting capability development in general practice.

NPS Medicine Wise is funded by the Commonwealth Government through the Department of Health, and work it is undertaking on the Choosing Wisely initiative should be linked to and inform the MBS Review currently underway.

PHNs have been charged with developing and supporting evidence-based health pathways, capacity development in general practice, and data collection and analysis to inform the planning and provision of health services. NPS Medicine Wise leads national work on better use of medicines. While NPS Medicine Wise has entered into bilateral arrangements with some PHNs, these are of limited scope. National coordination by the Department of Health is required to address the lack of a shared policy agenda and duplication of effort, in addition to ensuring consistency and collaboration in working with general practice at regional levels.

PHNs have the key role as regional coordinators and commissioners of primary health services, including capacity development in general practice and assessment of regional health needs to determine health priorities. NPS Medicine Wise works with consumers and health professionals to improve the way medicines and medical tests are used, including via education programs delivered to general practice. The following should be implemented to ensure the alignment of related activities:

- Working arrangements between NPS Medicine Wise and PHNs should be nationally-coordinated via the Department of Health to ensure policy coherence and a coordinated approach to program delivery. This should include consideration of roles and responsibilities for regional delivery of education and communications programs to general practice, data development, collection and access, and associated costs.
- This work should be conducted in formal partnership with PHNs at the regional level, based on a shared policy agenda, and coordinated by the Department of Health, with regular briefings provided back to PHNs.
- Best practice data governance practice based on the principle of 'collect once, use many times' should be implemented. Multiple agencies collecting data from general practice is an inefficient approach and does not engender positive relationships. PHNs should also have a role in regional primary health data governance.
- Data currently collected by NPS Medicine Wise on prescribing patterns has value for regional health needs assessments but is not readily accessible and should be customised to align with PHN priorities. Data development, access and costs should be determined with due consideration to the Commonwealth's health policy agenda and funding for this work.

6. Oral Health

Key Recommendations:
- The Government should extend eligibility for public dental services beyond concession card holders to lower income Australians.
- A performance and reporting structure focusing on outcomes rather than throughput should be developed.
- Appoint an Australian Chief Dental Officer to coordinate oral health policy.

The AHHA recommends the extension of public dental services eligibility beyond concession card holders to lower income Australians as part of the negotiations between the states and territories and the Commonwealth on the funding for public dental services.

The AHHA supports a performance and reporting structure focusing on outcomes, rather than throughput, through the development of oral health indicators, which might be tied to outcomes based funding when more timely and robust data collection and dissemination is in place to enable such a change. Investment in this data and indicator development work should be prioritised in 2016-17. The estimated cost of developing this framework is $1.0 million.

Funding allocations must reflect the full cost of providing care in rural and remote areas, smaller jurisdictions and to high needs groups.

Good oral health is fundamental to health, wellbeing and quality of life. A healthy mouth enables people to eat, speak and socialise without pain, discomfort or embarrassment. Oral health problems impact on general health. As well as common risk factors with chronic diseases, oral disease is significantly associated with major chronic diseases including cardiovascular disease, diabetes, stroke and respiratory disease. Poor oral health can also impact on birth outcomes, including preterm-births and low birth weight.[5]

Oral conditions are the second most expensive disease group to treat in Australia. Unlike other health services, the cost of oral health largely falls on the individual. In 2013-2014 individuals were responsible for 59.9 per cent of the total cost of dental care compared to only 15.2 per cent of the cost of all other health services.[6]

According to the National Dental Telephone Interview Survey, from 1994 to 2010, there was an increase in the proportion of adults avoiding visits to a dentist due to costs, from about 25 per cent to 30 per cent. For children, the overall trend was unchanged at around 14 per cent, but varied between 8.5 per cent and 17 per cent over this period.[7]

[5] Australian Government Department of Health. 2012. Final Report of the National Advisory Council on Dental Health.
[6] AIHW. 2015. Health expenditure Australia 2013-14. Health and welfare expenditure series no. 54. Cat. no. HWE 63. Canberra: AIHW.
[7] AIHW. 2014. Oral health and dental care in Australia: key facts and figures trends 2014. Cat. no. DEN 228. Canberra.

The groups of people who are least likely to be able to access proper care and treatment are those on lower than average incomes[8], people living in remote and very remote areas[9], Aboriginal and Torres Strait Islander people[10], aged care facility residents, people with disabilities, young adults on income support payments and sole parents.[11]

The 2014-15 Budget cut $650 million from dental programs across the forward estimates, in addition to expenditure cuts of $42.4 million made in the 2013-14 MYEFO.[12] In the 2015-16 Budget, 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, 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 services, with Commonwealth funding arrangements from 2016-17 being subject to negotiations with state and territory governments.[13,14]

In its 2013 election health policy, the Coalition was critical of the previous Labor Government's delayed commencement of oral health programs and the resulting negative impact on access for 'hundreds of thousands of Australians, 80 per cent of whom are concession card holders'. The Coalition promised to work with stakeholders, patient representatives and states and territories to improve the National Partnership Agreement for Adult Public Dental Services as necessary and to use 'the implementation of the Child Dental Benefits Schedule to inform the expansion of Medicare dental services more broadly. This would address adult services, including initial eligibility requirements for patients, appropriateness of the caps for treatment and schedule fees.'[15]

The AHHA supports the expansion of public dental services to lower income Australians to address the cost barriers and health inequities they currently experience.

The appointment of an Australian Chief Dental Officer is necessary to provide national coordination of oral health policy development and implementation of the National Oral Health Plan. This should be funded from 2016-17. The estimated cost of such an appointment is $0.5 million per annum.

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8 Sanders A.E. 2007. Social Determinants of Oral Health: conditions linked to socioeconomic inequalities in oral health and in the Australian population. AIHW cat. no. POH 7. Canberra: Australian Institute of Health and Welfare (Population Oral Health Series No. 7).

9 AIHW. 2014. Oral health and dental care in Australia: key facts and figures trends 2014. Cat. no. DEN 228. Canberra.

10 Australian Indigenous Health*Info* Net. Review of Indigenous oral health (available at http://www.healthinfonet.ecu.edu.au/other-health-conditions/oral/reviews/our-review).

11 Australian Government Department of Health 2012. Final Report of the National Advisory Council on Dental Health.

12 Russel, L. 2014. Analysis of 2014-15 health budget: unfair and unhealthy, Menzies Centre for Health Policy, University of Sydney.

13 Commonwealth of Australia. 2015. Budget 2015-16 - Budget Paper No. 2. Commonwealth of Australia.

14 Commonwealth of Australia. 2015. Budget 2015-16 - Budget Paper No. 3. Commonwealth of Australia.

15 The Coalition's Policy to Support Australia's Health System, August 2013, p 16 (available at http://parlinfo.aph.gov.au/parlInfo/download/library/partypol/2680604/upload_binary/2680604.pdf;fileType=application%2Fpdf#search=%22library/partypol/2680604%22).

7. Pharmaceuticals and Pharmacy

Key Recommendation:
- Reform in the pharmaceutical and pharmacy sector must be considered as part of a coordinated approach to achieving the objectives of the National Medicines Policy.

Reform in the pharmaceutical and pharmacy sector must be considered as part of a coordinated approach to achieving the objectives of the National Medicines Policy[16], across the primary, acute, aged care and disability sectors.

There are opportunities to implement a range of measures to achieve efficiency within the sector without impacting on quality of care for patients. These include:

- Reviewing existing Pharmaceutical Benefits Schedule (PBS) products for their continued appropriateness and efficient cost as research and development in pharmaceutical 'technology' continues to advance. The PBS program needs to reflect developments in the pharmaceutical sector, while at the same time providing value for money on the investment of health dollars being made.
- Using the negotiating power of the Commonwealth more effectively to purchase pharmaceuticals at more competitive prices. For example, it has been shown that Western Australia and one other Australian state where able to purchase pharmaceuticals at prices above which the PBS paid an estimated additional $750 million[17].
- Pursuing further efficiencies through the continuation of price disclosure mechanisms and increasing consumer confidence in and use of generic medicines.
- Implementing the recommendations from the Review of Pharmacy Remuneration and Regulation to ensure quality health outcomes are delivered through community pharmacy, access and quality use of medicines are promoted, and there is recognition of the contribution of pharmacists and pharmacy in the broader Australian healthcare sector.
- Ensuring that pharmacists are utilised to the full scope of their professional expertise, allowing innovation in the provision of health services across the primary, acute, aged care and disability sectors.

The AHHA supports a performance and reporting structure focusing on outcomes, rather than throughput, through the development of indicators, which might be tied to outcomes based funding when more timely and robust data collection and dissemination is in place to enable such a change. This performance and reporting structure should also be consistent across services (e.g. general practice, pharmacy, allied health, community health services) to enable comparisons to be made of innovations in scopes of practice and role substitution.

[16] National Medicines Policy document (http://www.health.gov.au/internet/main/publishing.nsf/content/national-medicines-policy).

[17] Duckett, S.J. with Breadon, P., Ginnivan, L. and Venkataraman, P. 2013. Australia's bad drug deal: high pharmaceutical prices, Grattan Institute, Melbourne.

8. Preventive Healthcare

Key Recommendation:

- The Government must prioritise developing and implementing preventive health strategies.

The Government must prioritise developing and implementing preventive health strategies. While investing in preventive health measures generates a short term cost, innovative initiatives can also create savings in reduced health care costs in the future. With the fourth Intergenerational Report highlighting the pressure that health costs will place on the Commonwealth budget, it is vital that preventive health strategies be encouraged to lessen the individual, intergenerational and health system burden which will otherwise emerge in the future.

In her 28 October 2015 address to the National Press Club, Commonwealth Minister for Health Sussan Ley underscored the value of better preventive health and early intervention measures. Through participation in the World Health Organisation, Australia has committed to reducing premature mortality from the four major non-communicable diseases by 2025. These include cardiovascular disease, cancer, chronic lung diseases and diabetes.

Hospital services accounts for around 40 per cent of health expenditure in Australia. Investment in effective prevention efforts and primary health care programs aimed at addressing these four disease groups will support reduction in hospitalisations, leading to lower hospital expenditure.

Health policy today will have a tangible impact on the problems faced by the health system in the future. With the Commonwealth, State and Territory governments currently facing budgetary pressure from rising health costs, it is vital that preventive health strategies be encouraged to lessen the individual, intergenerational and health system burden which will otherwise emerge in the future. Investing in preventive health measures is a low cost way of reducing this future fiscal pressure while also improving the wellbeing of all Australians.

Expenditure on preventive health measures can legitimately be viewed as contributing to fiscal repair by reducing future demand on the health system while simultaneously improving health outcomes for all Australians.

9. End of Life Planning

Key Recommendations:

- End of life care plans should be incorporated into aged care and My Health Record personal electronic records.
- An MBS item to support the central involvement of GPs in end of life planning.
- End of life planning is made part of the accreditation and quality framework.

Australia must formally embed planning for end of life care into both health and aged care practices. Australians should also be encouraged to include end of life care plans in their My Health Record.

Benefits and considerations include:

- Improved end of life planning can reduce hospitalisations and unwanted and often invasive life prolonging care, along with the avoidance of unnecessary medications and surgeries and their associated costs.
- End of life planning would benefit from continued research into new strategies to improve this area of care, create new interventions for management of pain and other symptoms, and to develop appropriate health technologies that better support high quality end of life care that is both aligned with the desires of the patient and enables all members of the health and care team to provide the right care.
- An MBS item could be established that supports the central involvement of GPs in end of life planning. This plan could be linked into a patient's ehealth record which would support care being provided that aligns to the wishes and needs of the patient, regardless of what part of the health system they access. Such an MBS item could form part of a set of linked items on chronic disease management and integrated care.
- Requirements for end of life planning should be included in relevant aged care facilities and services, and national health accreditation and quality standards.

Better end of life planning has the potential to improve patient outcomes while also providing savings to the health system. With an ageing population, this proposal is a sensible approach towards the dignified treatment of elderly Australians and for the health and aged care systems.

10. Social Impact Investing

Key Recommendations:

- The Commonwealth Government should work with state and territory health departments to pilot small scale social impact investing initiatives tied with research components to establish an Australian evidence base on the effectiveness of this novel financing model.

Using social impact investing to drive positive health outcomes for specific conditions or populations is very much in its infancy in Australia. But governments, such as New South Wales among others, are beginning to look at the international trend and considering how social impact investing can be used in Australia to drive outcome-focused improvements.

Social impact investing involves private investors funding outcome-focused interventions and governments paying back the principal as well as a return on the investment only once the program meets its agreed outcomes. The attractiveness of social impact investing lies in risk mitigation to governments, cash flow management for government departments and the potential to promote innovation and increase accountability in service delivery through public-private partnerships.

Impact investing in health would require a change in mindset away from discussions of whether private or public interests are responsible for treating ill-health. The focus shifts to the mitigation of ill-health by adjusting tastes and behaviours and the achievement of positive health outcomes.

Essential ingredients for success in pursuing impact investing in the health sector include the development of measurable and robust outcomes, niche investors seeking a return on a public good, the development of effective and innovative interventions and consensus among the parties throughout the journey.

Working together, Primary Health Networks and Local Health Districts are well-placed to be agents of positive change in realising better population health outcomes while being prudent fiscal stewards of public funds.

PHNs and LHDs have an opportunity to engage in impact investments in order to respond more directly to local needs. A funded emphasis on better health outcomes rather than simply focusing on payments based on activity is consistent with the commissioning role envisaged for the PHNs.

More work is needed to determine the applicability of social impact investing to the Australian primary and acute healthcare environment. The Commonwealth Government should work with state and territory health departments to pilot small scale impact investing initiatives tied with research components to establish an Australian evidence base on the effectiveness of this novel financing model.

11. Reform of the Federation - A Hospital Benefit

Key Recommendation:

- If a Hospital Benefit is introduced, then the price of each item must be independently set and there must be a reasonable level of certainty around the ongoing share of funding responsibilities.

One of the options raised in the Reform of the Federation Discussion Paper was to establish a Hospital Benefit that would be similar to the operation of the Medicare Benefits Schedule. If this option is pursued then the Commonwealth must ensure that:

- The price of each Hospital Benefit item is set by a fully independent body such as the Independent Hospital Pricing Authority. These prices must also be reviewed annually.
- There is certainty around the ongoing share of funding responsibility between the Commonwealth and the states and territories.

While the AHHA would in principle support the introduction of a Hospital Benefit if the above two requirements are met, it is also noted that such a change in funding mechanism would not address problems of a fragmented healthcare system and the need for better coordinated care across the primary, acute, aged and disability care sectors.

The AHHA supports the option in the Reform of the Federation Discussion Paper to introduce individualised care packages for patients with, or at risk of developing, chronic or complex conditions.

Conclusion

Leadership in the field of health needs to represent more than just financial cuts over a four year planning horizon. The 2016-17 Budget must instead present effective solutions that compromise neither the short term nor long term health of Australians or our health system. By implementing sensible changes in health policy, more can be achieved with our existing health system without having to commit additional resources.

In particular, with a number of reform processes currently underway on different aspects of the Australian healthcare system, there is the opportunity to achieve meaningful change that could produce improved health outcomes in tandem with economic savings.

The proposals presented in this submission all represent the more effective and efficient use of existing resources and health infrastructure, not simply a call for additional public funding except in only very small and targeted ways. Fiscal sustainability within the health sector requires a more nuanced approach with a holistic view across both the sector and over generations. As the nation's income increases with a rising gross domestic product, the opportunity is to spend this wisely on services vital to us all, both as individuals and collectively.