ahha

australian healthcare & hospitals association

the voice of public healthcare®

2021-22 PRE-BUDGET

Submission to Treasury

29 January 2021

australian healthcare & hospitals association

the voice of public healthcare

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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INTRODUCTION

The Australian Healthcare and Hospitals Association (AHHA) welcomes this opportunity to provide this submission in advance of the 2021–22 Australian 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 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.

The 2021-22 Budget provides the opportunity to take decisive steps to reform the Australian healthcare system and to provide additional resources in areas of known need.

There have been substantial and damning reports released into mental healthcare and aged care services in Australia that clearly signal urgency for reform. The Government should act on the findings of these two inquiry processes due to the compelling nature of the problems identified.

AHHA understands that 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, and the importance of universal care to the wellbeing of individuals and our society more broadly has been highlighted during 2020, first with the Black Summer fires and then during the Covid-19 pandemic. The 2021–22 Budget must ensure there is continued support for an effective, accessible, equitable and sustainable healthcare system focused on quality outcomes.

All states and territories have now signed the 2020-25 Addendum to National Health Reform Agreement and meaningful action must be taken around the various areas for reform listed in this agreement.

The current fee-for-service funding model in Australia places the focus on throughput of patients rather than sustained, improved health outcomes being achieved. A fundamental area for reform of our healthcare system, as identified in Schedule C of the Addendum, is to move from volume-based care to a system of value-based healthcare, where patients are at the centre and the outcomes achieved in the provision of this healthcare are the focus.

This submission outlines a number of areas of reform to the healthcare system that are achievable with leadership by the Australian Government, working in cooperation with state and territory governments, Primary Health Networks and other groups. The way our healthcare system is organised needs to be adapted to more effectively deliver 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 national health policy leadership.

RECOMMENDATIONS

Moving from Volume to Value (pages 8 - 9)
• Fund value-based healthcare training, supporting resources, mentoring and communities of practice, tailored to an Australian audience and context, for Australian health services. • Develop a web-based clearinghouse of quality-assessed evidence on value-based healthcare • Resourcing to finalise and implement the National Health Information Strategy, enabling use of patient-reported outcome and experience measures for patient care, and performance benchmarking.
Aboriginal and Torres Strait Islander Health (pages 10 - 11)
• Build a cohort of Aboriginal and Torres Strait Islander people as health coaches to be employed in very remote communities, to support primary healthcare efforts. • Invest in the design and development of appropriate training to support micro-credentialing within the Aboriginal and Torres Strait Islander Health Workers training pathway.
Advance Care Planning and Palliative Care (pages 12 - 13)
• Develop a nationally consistent legislative framework to support end-of-life decision-making and advance care planning. • Improve integration of advance care planning documents in My Health Record with primary care, hospital, community and aged care electronic records, with alerts of their existence. • Introduce MBS items to better support the involvement of general practitioners, allied health professionals, nurse practitioners and primary care nurses in advance care planning and palliative care. • Introduce MBS items to support the involvement of palliative care specialists in case-conferencing and family meetings. • Develop a national minimum data set for non-admitted patients' palliative care.
Aged Care (pages 14 - 16)
• Provide extra funding for Home Care Packages. Phase out supply caps and invest in increased workforce capacity within the sector. Invest in data development to measure and monitor unmet need and equity of access to aged care services. • Improve access to primary health care, including oral and allied health care, in the aged care sector. Introduce appropriate funding mechanisms for team-based models of care, and training and support for primary care nurses and nurse practitioners to work with general practitioners and allied health professionals as part of an expanded primary care team • Continue work to develop a national set of quality indicators for aged care services, including measurement, monitoring and public reporting from all aged care service providers. • Initiate immediate steps to enable meaningful system reform of the aged care sector, as proposed through the Interim Report from the Royal Commission into Aged Care.

Alcohol and Other Drugs (pages 17 - 19)
• Improve the size and focus of investment in the alcohol and other drugs treatment sector by updating and implementing the Drug and Alcohol Services Planning Model (DASPM). • Increase access and affordability of opioid pharmacotherapies • Increase service coordination, accountability and planning across the alcohol and other drugs treatment sector. • Invest in service and workforce capacity through the establishment and funding of an Alcohol and Other Drugs Treatment Sector Capability Fund.
Allied Health Services in Rural and Remote Communities (pages 20 - 22)
• Develop an allied health workforce dataset to support evaluation of changes in models of care. • Provide resourcing to implement an Allied Health Rural Generalist Pathway, including investment in an accreditation program.
Australian Centre for Disease Control (pages 23 – 24)
• Establish an Australian Centre for Disease Control as a statutory body to strengthen Australia's capacity to respond to new and re-emerging communicable diseases threats.
Children's Mental Health (pages 25 – 28)
• Resource Karitane to improve access across Australia to Internet-Parent Child Intervention Therapy (I-PCIT), a gold standard telehealth treatment intervention for young children with behavioural and disruptive conduct disorders. • Resourcing should include support for workforce capacity building, delivering training to develop PCIT clinicians in Child and Adolescent Mental Health Services across Australia.
Climate and Health (pages 29 – 31)
• Develop and implement a National Climate and Health Strategy that acknowledges environmental change, and the social and ecological determinants of health as key drivers of health system value, prevention, and improved outcomes. • Provide funding to support research into the health impacts of climate change on health with emphasis given to vulnerable population groups. • Provide funding to PHNs to develop evidence-based climate and health strategies tailored to the specific needs of their local communities.

Disaster and Emergency Management (pages32 – 33)
• Incorporate a defined role for primary care into current and future disaster and emergency prevention, preparedness, response and recovery processes. • Provide recurrent funding to PHNs, with authority through national and state and territory governments, to coordinate regional primary healthcare responses before, during and after natural disasters and emergencies.
Medicines (page 34)
• For states and territories participating in the Public Hospital Pharmaceutical Reforms, 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.
Mental Health (pages 35 – 37)
• Enable mental health policy reforms identified by the Productivity Commission in areas including governance and accountability; regional planning, decision making and commissioning; and monitoring evaluation and research. • Implement arrangements to support joint funding and planning at the local level for mental healthcare services between Primary Health Networks, Local Hospital Networks and community service providers. • In long term reform, ensure implementation of funding models that prioritise value and address social, cultural, and ecological determinants of health. • Embed support for the equitable implementation and uptake of innovative virtual solutions and digital platforms that augment and support in person mental health care.
Oral Health (pages 38 – 40)
• Provide $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. • Allocate funding to reflect the cost of providing care in rural and remote areas, smaller jurisdictions and to groups with higher needs. • 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. • Provide $50 million over the next three years to fund water fluoridation infrastructure. • Actively promote the Child Dental Benefits Schedule to eligible families. • Treble the number of scholarships for Aboriginal and Torres Strait Islander dental students. • Provide capital investment for every dental school to have a teaching clinic in a local AMS. • 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

Preventive Healthcare (pages 41 – 45)

- Increase preventive health funding to 2.3% of recurrent expenditure on health.
- Commit resources to support needs assessments and public health capacity at the regional level allowing for the implementation of national, regional and local prevention and health promotion agendas, adjusted to suit the specific needs of the local communities, e.g. the mass roll out of COVID-19 vaccination.
- Ensure the forthcoming National Preventive Health Strategy addresses climate change and the social, ecological and cultural determinants of health in addition to biological and behavioural risk factors; and data and technology development.
- Adopt a 'Health in All Policies' and cross portfolio prevention approach to ensure shared responsibility and accountability for the success of prevention initiatives. Leadership should sit within health with all relevant portfolios included in implementation and decision-making processes (e.g. in social services, education, environment, mental health, transport, infrastructure, energy, population, cities, agriculture and regional development).
- Recognise the rapid developments occurring in technology and data, and capitalise on these opportunities to revolutionise, not just mobilise, preventive health.
- Develop a primary health care national minimum dataset to inform a better understanding of population health and opportunities to mobilise preventative action.
- Invest in evidenced-based strategies to discourage the consumption of sugar-sweetened beverages, including introduction of a 20% ad valorem sugar-sweetened beverages tax, with revenue hypothecated for preventive health measures.
- Implement a five-year transition period to shift from voluntary to mandatory implementation of the Health Star Food Rating System.

Private Healthcare (page 46)

- Fund the Productivity Commission to conduct an independent comprehensive review of government support for private healthcare in Australia, which:
    - assesses the value to the Australia community, and the impact on the public health system, of government support of private healthcare through subsidies and other policies.
    - assesses the most effective ways that the Australian Government can support private healthcare, such that it complements and does not compromise the integrity of Australia's universal healthcare system, Medicare.

Specialist Referrals (pages 47 – 48)

- Conduct an independent, evidence-based review of the specialist referral system, informed by the development and implementation of a national strategy for capturing and reporting standardised specialist referral-related metrics.
- Amend specialist referral rules to:
    - decouple specialist billing from referral status and introduce protections to prevent increased costs for patients under long-term specialist care.
    - expand health professional referral rights and adoption of a linear evidence-based model of patient transfer through the health system to optimise use of the health workforce.

Telehealth and Virtual Healthcare (pages 49 – 51)
• Fund a research program to explore the practical implementation of virtual care technologies in the Australian setting, including an evaluation of what has worked, what hasn't worked and what can be done better/differently. • Develop funding models that will support the use of, and equitable access to, virtual care technologies in person-centred models of care.

MOVING FROM VOLUME TO VALUE

Key recommendations:

- Provide value-based healthcare training, supporting resources, mentoring and communities of practice, tailored to an Australian audience and context, for Australian health services.
- Develop, promote and maintain an Australian-tailored web-based clearinghouse of quality-assessed evidence on value-based healthcare to support the transition to this new model for funding and delivering better health outcomes.
- Provide resourcing to finalise development and implement the National Health Information Strategy, with the appropriate governance, infrastructure and reporting in place to enable the use of patient-reported outcome and experience measures in patient care, in addition to performance benchmarking at the level of the individual clinician, service, state/territory and nationally.

Opportunity: Consistent with the *Addendum to the National Health Agreement 2020-25* signed by all Commonwealth, state and territory governments, 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 in health care.

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 health care.[1,2]

The long-term health reform principles in Schedule C includes paying for value and outcomes as a critical priority. State and territory health departments and agencies are currently undertaking work on value-based care, and some individual service providers are also leading programs. 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

Proposal: 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 health care**—the change management process to align national and institutional goals, enable clinician leadership and engage broader stakeholder buy-in.
2. **Measuring outcomes and costs**—collecting and using data to drive change.
3. **Implementing integrated and patient-centred care**—redesigning care models for value, including journey mapping to ensure a shared understanding of patient experience.

[1] Australian Healthcare and Hospitals Association 2020, *Healthy people, healthy systems: A Blueprint for otucomes-focused, value-based health care* with *Case Study Exemplars,* Australian Healthcare and Hospitals Association, www.ahha.asn.au/blueprint.

[2] Establishment of the Australian Centre for Value-Based Health Care including training and publication of research www.valuebasedcareaustralia.com.au

4. **Enabling outcomes-based payment approaches**—redesigning funding and payment models for value.

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

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

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

Cost: $1.0 million annually

WEB-BASED CLEARINGHOUSE

Proposal: 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 health 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. The Australian Government Department of Health and AHHA would then be able to 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

MEASURING OUTCOMES THAT MATTER TO PATIENTS

Proposal: National health data must prioritise the collection of patient-recorded outcome and experience measures (PROMs and PREMs) to enable a patient-centred, outcomes-focused and value-based approach to the delivery of healthcare.

Australian Government leadership and investment in implementing the collection of such data will enable the appropriate governance, infrastructure and reporting to be in place, which can then be used to support patient care and performance benchmarking at the level of the individual clinician, service, state/territory and nationally. This will require further development of the Australian Health Performance Framework to include outcome measures, building on work already being done in some jurisdictions and facilitating benchmarking with international data including datasets being developed by the OECD. Further details are available in a report published by the AHHA's Australian Centre for Value-Based Health Care.[4]

[3] 42nd International Hospital Federation World Hospital Congress Redefining Healthcare Workshop—Implementing Value-based Health Care, facilitated by Professor Elizabeth Teisberg, Brisbane, 9 October 2018.

[4] Raymond, K. Reforming for value: opportunities for outcome-focused national health policy. Viewed 13 December 2019, https://valuebasedcareaustralia.com.au/wp-content/uploads/2019/10/deeble_issues_brief_no._33_reforming_for_value_opportunites_for_outcome-focused_national_health_policy.pdf

ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

Key recommendations:

- Build a cohort of Aboriginal and Torres Strait Islander people as health coaches to be employed in very remote communities, to support primary healthcare efforts.
- Invest in the design and development of appropriate training to support micro-credentialing within the Aboriginal and Torres Strait Islander Health Workers training pathway.

Opportunity: The intended outcome is to improve the health of people in remote and very remote Aboriginal and Torres Strait Islander communities, with additional benefits including community development, local employment and skills training.

Proposal: The project will use locally recruited, trained and managed Aboriginal or Torres Strait Islander people as health coaches to intensify primary healthcare efforts in remote and 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.

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

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? 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 and support the provision of mental health services.

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.

ADVANCE CARE PLANNING AND PALLIATIVE CARE

Key recommendations:

- A nationally consistent legislative framework is developed to support end-of-life decision-making and advance care planning.
- Improve integration of advance care planning documents in My Health Record with primary care, hospital, community and aged care electronic records, with alerts of their existence.
- There is system-wide transformation of palliative care services and models of care to better respond to end-of-life needs and to meet increasing demand. These changes will require a coordinated and integrated approach across primary, community, aged care, specialist and hospital care.
- Medicare Benefit Schedule items are introduced to support the involvement of general practitioners, allied health professionals, nurse practitioners and primary care nurses in advance care planning and palliative care.
- Medicare Benefit Schedule items are introduced to support the involvement of palliative care specialists in case-conferencing and family meetings.
- A national minimum data set for non-admitted patients' palliative care is developed.

Opportunity: To improve advance care planning and palliative care services for all Australians.

Context: Australians are living longer, with the number of deaths in Australia set to double over the next 25 years.[5] Palliative care aims to improve the quality of life of people with life-threatening illness, their families and carers. This involves management of disease symptoms, psychosocial and spiritual aspects of care, as well as effective coordination of services across the health system.

Health and aged care services have inadequate capacity to provide consistent and coordinated care for current and future palliative care needs.

COVID-19 has put additional strain upon the health and aged care sectors. An inability to undertake usual face-to-face contact, family gathering, and memorialisation practises due to differing visitation policies, isolation practices, and border restrictions has had consequences for healthcare access and thel grief and bereavement responses of patients, their families and carers. The short and long-term health implications of these will be have a significant impact on many Australians, requiring strategic planning and investment by governments and service providers.

AHHA recognises that balancing healthcare expectations within the resource-constrained health system to provide satisfactory palliative care is challenging. While hospitalisation at end-of-life is common, with improved advance care planning it is possible to firstly improve care by reducing hospitalisations and unwanted and often invasive life prolonging treatment, and secondly to reduce their associated costs by providing access to less acute inpatient palliative or hospice care.[6]

[5] Swerissen H and Duckett S 2014, *Dying well*, Grattan Institute, Melbourne.

[6] McCarthy IM, Robinson C, Huq S, Philastre M and Fine RL 2015, 'Cost savings from palliative care teams and guidance for a financially viable palliative care program', *Health Services Research*, vol. 50, no. 1, pp. 217–236.

Proposals: AHHA supports the Senate Community Affairs Reference Committee recommendation to harmonise laws across all jurisdictions on advance care planning documents and substitute decision-makers.[7] This will support a nationally consistent approach protecting clinicians from medico-legal risk and providing a decision-making framework to support patients in accessing the care they wish to receive.

My Health Record accepts uploads of advance care planning documents. However, access to these documents should be enhanced, with greater linkage and alerts to the existence of these documents in primary care, hospital, community and aged care electronic health records. This will facilitate continuity and coordination of care, improve clinician awareness and assist in providing care that aligns with Advance Care Directives. Additionally, such systems could potentially prompt discussion and documentation of advance care planning at key times in the patient journey, including:

- At agreed milestones (such as 75+ health assessments);
- During chronic disease planning and with the development of multiple comorbidities; and
- At onset of dementia.

Review of the Medicare Benefit Schedule items for the provision of advance care planning and palliative care are also necessary. This should include establishment of items to support involvement of general practitioners, allied health professionals, nurse practitioners and primary care nurses in advance care planning and palliative care. Additional items should also be established to support the involvement of palliative care specialists in case conferencing and family meetings.

Data on palliative care are not comprehensive, particularly across the community-based sector, making it very difficult to measure the number of patients accessing services and the total government expenditure across states and territories.[8] Standardised high-quality data supports outcomes-focused care, recognising community need and supporting allocation of resources. It is recommended that funding is allocated to engage with Primary Health Networks, and states and territories to develop a palliative care data collection framework. This will provide a minimum data set for non-admitted patients' palliative care to support increased access to high quality regionally appropriate care.

Better advance care planning and palliative care coordination have 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 older Australians, those living with chronic diseases, and for the health and aged care systems.

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7 Community Affairs Reference Committee (CARC) 2012, *Palliative care in Australia*, Community Affairs References Committee, The Senate, Commonwealth of Australia, Canberra.

8 Productivity Commission 2017, *Introducing Competition and Informed User Choice into Human Services: Reforms to Human Services – Inquiry report*, no. 85, Productivity Commission, Canberra.

AGED CARE

Key recommendations:

- The Australian Government must take immediate action to reduce waiting times by providing extra funding for people approved for Home Care Packages. This will require the Australian Government to phase out supply caps and invest in increased workforce capacity within the sector, in addition to investing in the development of better data to measure and monitor unmet need and to ensure equity of access to aged care services.
- Access to primary health care, including oral and allied health care, must be prioritised in the aged care sector. The Australian Government should develop appropriate funding mechanisms for team-based models of care, including training and supporting primary care nurses and nurse practitioners to work with general practitioners and allied health professionals as part of an expanded primary care team, and the use of digital health technologies, within residential aged care facilities.
- Work to develop a national set of quality indicators for aged care services should continue, including measurement, monitoring and public reporting from all aged care service providers.
- Initiate immediate steps to enable meaningful system reform of the aged care sector, as proposed by the Royal Commission into Aged Care Quality and Safety.

Opportunity: 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 need them. Aged care services must be of high-quality and responsive to the diversity of need, with independent monitoring, transparent public reporting and accountability upheld.

Context: The Royal Commission into Aged Care Quality and Safety Interim Report handed down in October 2019 described a neglectful system that is cruel and discriminatory.[9] The interim report found the aged care system fails to meet the needs of its older, vulnerable citizens and that a fundamental overhaul of the design, objectives, regulation and funding of aged care is required in Australia. It concluded that funding from the Australian Government should be forthcoming to ensure the timely delivery of home-based aged care services.

Despite the Australian Government announcing an additional investment of $1.6 billion for Home Care Packages in the October 2020 budget, access to home care packages remains limited.[10] There are currently more people waiting for packages at their approved level than are currently receiving packages[11]. As of 30 September 2020, over 62,000 Australians were waiting for a Home Care Package at their appropriate level, with an average expected wait time of more than 12 months.[12] A consequence of delays in obtaining the right Home Care Package is that people may be forced into more expensive residential care when they would otherwise prefer, and it would be more cost

[9] Royal Commission into Aged Care Quality and Safety 2019, *Royal Commission into Aged Care Quality and Safety Interim Report: Neglect*, Volume 1, viewed 28 January 2021, https://agedcare.royalcommission.gov.au/publications/interim-report-volume-1

[10] Australian Government 2020, *Budget 2020–21: Ageing and aged care,* viewed 28 January 2021,

[11] Australian Government Department of Health 2020, *Home Care Packages Program Data Report 1st Quarter 2020-21,* viewed , https://gen-agedcaredata.gov.au/Resources/Reports-and-publications/2020/December/Home-care-packages-program-data-report-1-July%E2%80%93-30-

[12] ibid.

effective, to remain at home. Accordingly, the Royal Commission into Aged Care Quality and Safety noted in the interim report that it would likely take $2–2.5 billion per annum to provide access to all people on the waiting list at the level of care they needed.

Various models are used in the provision of general practitioner services in residential aged care, with advantages and disadvantages to each.[13] Flexible, outcomes-focused, team-based models of care have been proposed to both ensure the health and social needs of residents are met and the capability of the workforce is built.[14]

The coronavirus (COVID-19) pandemic has compounded existing problems and highlighted workforce issues within the aged care sector. As of 22 January 2021, 678 COVID-19 deaths (from 2,029 total cases) have occurred in residential aged care facilities.[15] This represents approximately 74% of all COVID-19 deaths in Australia, a high proportion by international standards.[16] Notably, there have also been 2,227 recorded cases of COVID-19 amongst staff at residential aged care facilities. Indeed, transmission within residential aged care has been purported to result from a broad range of factors, including staffing levels, casual staff working across multiple facilities, inadequate monitoring, poor communication, and insufficient personal protective equipment (PPE). These challenges have been further exacerbated by low wages and limited training opportunities for some workers in residential aged care facilities.

Proposal: The various documented shortcomings within the aged care sector in Australia have been known for considerable time. The Interim Report of the Royal Commission into Aged Care Quality and Safety states the need for fundamental reform and redesign of the aged care system. This report also foreshadows that the Final Report to be provided to the Commonwealth Government on 26 February 2021 will recommend a whole-of-system reform and redesign.

The Australian Government should therefore initiate immediate steps to reduce waiting times for people with approved Home Care Packages, invest in increased workforce capacity, improve monitoring of safety and quality, enhance the capacity of residential aged care facilities to respond to infectious diseases and enable broader meaningful system reform of the aged care sector.

This should include:

- Funding to rapidly improve access to home care packages, reduce waiting list times, and identify barriers to accessing home and consumer directed care.
- Development of an updated aged care workforce strategy, with a focus on improving the skills and training of aged care staff and ensuring appropriate staffing ratios (dependant on the number and acuity of care needs of residents).
- Prioritising access to primary health care, including oral and allied health care, in the aged care sector. Innovative, team-based models of care should be supported, including funding to train and support primary care nurses and nurse practitioners to work with general

[13] Reed, R (2015). Models of general practitioner services in residential aged care facilities. Australian family physician, 44(4), pp. 176- 9, viewed 29 January 2021, https://pubmed.ncbi.nlm.nih.gov/25901399/

[14] Royal Commission into Aged Care Quality and Safety 2019, *EXHIBIT 14-05-WIT.0618.0001.0001 - Witness Statement of Dr Paresh Dawda,* viewed 29 January 2021, *https://agedcare.royalcommission.gov.au/media/26401*

[15] Australian Government 2021, COVID-19 outbreaks in Australian residential aged care facilities, viewed 28 January 2021, https://www.health.gov.au/sites/default/files/documents/2021/01/covid-19-outbreaks-in-australian-residential-aged-care-facilities-22-january-2021.pdf

[16] Cousins, S. (2020). Experts criticise Australia's aged care failings over COVID-19. *The Lancet (World Report)*, 396(10259), viewed 28 January 2021, https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)32206-6/fulltext#articleInformation

practitioners and allied health professionals as part of an expanded primary care team and the use of digital health technologies within residential aged care facilities.

- Aged care services are supported to deliver care to Aboriginal and Torres Strait Islander people that is flexible, adaptable, and culturally safe.
- Primary care, palliative care, pain management and chronic disease management being aligned with the quality of care available to other Australians.
- Access to clinically appropriate, high-quality and safe primary care and specialist care being available to people receiving aged care services when required.
- COVID-19 Medicare Benefits Scheme telehealth items for services provided by primary healthcare providers, including mental health services, should be extended indefinitely to allow flexible access in aged care facilities.
- State and territory public dental services should be adequately resourced to deliver oral health care for eligible aged care residents.
- Residential aged care services must enable timely access to health professionals able to prescribe and dispense appropriate medicines.
- All residential aged care services should be able to administer medicines for their residents 24 hours per day and seven days a week.
- Monitoring, evaluation, and public reporting of residential aged care service performance is needed around:
    - Access, quality, safety and outcomes for primary care services and frequently used healthcare services in residential aged care facilities;
    - Preventable hospitalisations; and
    - Clinical governance in relation to healthcare provided in residential aged care facilities.
- Work to develop a national set of quality indicators for aged care services should continue, with measurement, monitoring, and public reporting mandatory for all aged care service providers.
- Funding instruments for identifying care needs and allocating resources must be evidence-based, responsive and flexible to support the provision of appropriate and timely care; and should support moving towards a value-based approach to funding aged care.
- Arms-length assessment processes should be established for service providers to ensure independence when determining eligibility and classification for aged care.
- National standards for aged care information systems should be established to ensure that systems are fit-for-purpose and able to accurately capture evidence-based performance and outcomes data to facilitate transparency of performance around care quality and safety.
- Funding for information systems that embed interoperability requirements to enhance communication between health and disability services and providers. Interoperability with My Health Record must be prioritised.
- Aged care providers must be supported to introduce standardised tracking of evidence-based health outcomes and cost of care.

ALCOHOL AND OTHER DRUGS

Key recommendations:

As a member of the national alcohol and other drugs (AOD) coalition, AHHA supports the recommendations of the coalition to:

- Improve the size and focus of investment in the AOD treatment sector
- Increase access and affordability of opioid pharmacotherapies
- Increase service coordination, accountability and planning
- Invest in service and workforce capacity.

(Note: the full 2021-22 budget submission of the national AOD coalition can be accessed here, and is summarised below.)

Opportunity: In response to the COVID-19 pandemic, the national AOD coalition calls on the Australian Government to improve coordination across all levels of government to enhance the integration and delivery of alcohol and other drug treatment services. Investment in AOD treatment leads to substantial financial and social benefits for all.

Context: The COVID-19 pandemic has had a significant impact on alcohol and other drug treatment services across Australia. Patterns of alcohol and drug use changed, with some evidence of reduced use of some drugs that are typically associated with social gatherings and events. However, there is also evidence of significant increased and harmful use of alcohol and other drugs by other people, which appears to have persisted after restrictions were lifted.

In addition, the pandemic also weakened many factors that protect people from AOD related harm. It not only impacted patterns of use, it also affected clients' access to treatment and impacted profoundly on the workforce which deliver these vital services. It is also well known that AOD services provide a critical conduit to social connection which minimises the impact of social isolation for some of the most disadvantaged Australians.

A survey of treatment providers across Australia undertaken by the State and Territory Alcohol and Other Drug Peaks Network, revealed that around 7 out of 10 providers had experienced an increase in demand by 40% or more for their services.[17]

Providers noted significant increases in co-occurring issues and complexity among their clients, with almost 90% observing increases in reported mental health concerns and significant increases in those reporting financial stress and family and domestic violence.

Fundamental to our recommendations, is the development of a national response to both the lack of existing capacity in the AOD sector and to the changing levels of alcohol and other drug use resulting from the pandemic. The response must also include better national coordination and investment in rural and regional services, workforce capacity and development, service infrastructure, and the more effective use of data.

[17] https://qnada.org.au/wp-content/uploads/2020/10/Fin_20200728_Covid-Impact-Survey-Summary-Report.pdf

1. Improve the size and focus of investment in the AOD treatment sector

It is proposed that the Federal Government and State and Territory governments commit to funding alcohol and other drugs treatment in the same way that it does for other health programs and with 50% matched funding:

- Based on needs-based population planning.
- Through implementation of the Drug and Alcohol Services Planning Model (DASPM) and cognizant of relevant national and state frameworks to ensure investment in treatment is targeted.
- Delivered in those areas and to those people that need it most.
- Through innovation that improves access, particularly for people in regional, rural and remote areas (e.g. telehealth and digital access options)

2. Increase access and affordability of opioid pharmacotherapies

This government has taken steps to improve health affordability for many in the community least able to afford their medicines. Unfortunately, it does not help those in the community relying on access to PBS treatments through the Opioid Dependence Treatment (ODT) Program.

It is recommended that the government move to standardise the payments charged for access to Opioid Dependence Treatment (ODT) Program medicines consistent with monthly PBS script co-payments. These payments should be recognised as a co-payment for the purposes of the *National Health Act 1953* and therefore count towards a consumer's annual PBS safety-net.

In addition, it is recommended government consider supporting any ongoing subsidy of additional services that pharmacy consider are not covered by the PBS co-payment, as part of the increased investment in programs funded under the Seventh Community Pharmacy Agreement, consistent with the government's support of direct funding for Dose Administration Aids, Medicine Reviews and other similar services.

3. Invest in service coordination, accountability and planning

An effective and well-coordinated system needs a strong and properly funded national peak body. For several years there has been no funding for a national AOD Peak. It is therefore recommended that the newly established national AOD peak body, the Australian Alcohol and Other Drugs Council (AADC), be immediately and adequately funded to support the planning, consultations and coordination required to implement the recommendations contained in this submission, and to support the Department of Health in co-designing programs with service providers and consumers.

Within the AOD sector, there are many sources of data which are regularly collected and reported on. That said, it has been identified that the utility of this information is reduced given the delay in time between the data's collection and its reporting. We know, however, that as in other areas of policy, data can be an enabler of real-time evidence-based policy and practice decision-making. We recommend a review be undertaken of existing data sources, their strengths and limitations, with a view to establish nation-wide data sets that enable timely access to data to inform decision-making. Such a process should be undertaken in consultation with consumers, clinicians and researchers.

4. Invest in service and workforce capacity

Underpinning an effective AOD treatment services sector is a sufficiently sized, well-supported and well-trained workforce.

Within the previous pre-budget submission, it was recommended that an Alcohol and Other Drugs Treatment Sector Capability Fund be established. Such a fund could not only resource improvements to the capital works and physical infrastructure of services, but importantly, could support the effectiveness of the current workforce and the growth of the workforce that will be required to meet demand. Some areas that could be considered may include:

- Recruitment and retention of staff;
- Professional development opportunities;
- Enhanced leadership training;
- Mentoring programs and stress management; and
- Predictors of engagement.

Cost: Recommended additional AOD federal budget staging and costs are:

Program	*2021-22*	*2022-23*	*2023-24*	*2024-25*	*2025+ p/a*
Fund the new National AOD Peak Body (AADC)[a]	*$1.57M*	*$1.58M*	*$1.61M*	*$1.66M*	*$1.71M*
Immediate correction of ERO and indexation prior to implementation of DASPM[b]	*$TBC*	*$TBC*	-	-	-
DASPM national update[c]	*$500,000*	-	-	-	-
DASPM implementation plan	-	*$300,000*	*$200,000*	*$200,000*	*$200,000*
Implement DASPM, including infrastructure and workforce development[d]	-	-	*$88M*	*$176M*	*$264M*
Establish a Capability Fund[e]	*$20M*	*$20M*	-	-	-
Increase access and affordability of opioid pharmacotherapies[f]	*$TBC*	*$TBC*	*$TBC*	*$TBC*	*$TBC*
Total	*$22.1M+*	*$21.8M+*	*$89.8M+*	*$177.8M+*	*$265.9M+*

[a] Total income for a properly funded national peak, including core funding, start-up costs in year 1, and a series of time limited projects and programs to be negotiated with the Department of Health, designed to support: sector engagement and representation; consultation and coordination; sector capacity building; information dissemination; and policy research and advice.

[b] The Department of Health would have better estimates for this amount.

[c] This assumes update of epidemiology, review and update care packages via national consensus process, revise program logic, include Aboriginal and Torres Strait Island packages and deal with rural/regional/remote and scaling issues in the estimate.

[d] Implementing treatment funding in line with DASPM projections: DASPM projects that half the number of people who need treatment are able to access it. Current AOD treatment budget, all up is $1.2 billion including private/public and all levels of govt. Recommended funding assumes there is a need for another $1.2 billion to meet demand. The amounts included in this table reflects the additional funding contribution required of the Federal Government (and does not include the State & Territory contributions), minus private funding and that provided to generalist GP, Medicare, and hospitals etc.

[e] Includes funding for capital works and new facilities, for workforce development, consumer involvement, and capacity building initiatives.

[f] The Department of Health would have better estimates for this amount.

ALLIED HEALTH SERVICES IN RURAL AND REMOTE COMMUNITIES

Key recommendations:

- The Australian Institute for Health and Welfare (AIHW) should be resourced to develop and manage a national allied health workforce minimum dataset that moves beyond distribution, supply and demand, to also support the pursuit and evaluation of outcomes-focused and value-based changes in scopes of practice and models of care.
- Support is needed for implementing and embedding the Allied Health Rural Generalist Pathway across the three components of the Pathway, including investment in an accreditation program.

Opportunity: To provide coordinated support, facilitating access to allied health services that will meet the needs of rural and remote communities, with improved distribution of the rural allied health workforce and access to quality services.

Context: The 2020 Report[18] by the previous National Rural Health Commissioner provides recommendations to Government on improving access, quality and distribution of allied health services. AHHA in principle supports these recommendations.

AHHA reiterates its advice to the previous Commissioner that governance is critical to enabling quality, access and service distribution improvements to be carried out most effectively. A broad range of functions are required which vary in the extent to which:

- There should be an expectation of Australian Government support.
- Existing entities hold the expertise and experience required.
- Efficiencies can be gained through existing entities and structures.
- The influence of vested interests will be an impediment to reform and will need to be managed.
- Community need must be addressed as the primary purpose through governance structures.

Investment in allied health services in rural and remote communities should recognise the roles of existing entities in identifying and addressing community needs, and integrate with and build on, not duplicate or conflict with, these responsibilities and accountabilities. Actions taken should be determined not only by evidence and the needs of a particular population, but also by the pattern of services and infrastructure that has evolved in each community.

Investment should reflect the agreement expressed in the 2020-25 Addendum to the National Health Reform Agreement for reforms relating to better coordinated care through joint planning and

[18] National Rural Health Commissioner, 2020, *Report for the Minister for Regional Health, Regional Communications and Local Government on the Improvement of Access, Quality and Distribution of Allied Health Services in Regional, Rural and Remote Australia*, National Rural Health Commissioner, Commonwealth of Australia, Canberra.

funding at a local level, in particular by Local Hospital Networks (or equivalent) and Primary Health Networks, including co-design with consumers.

DATA ON ALLIED HEALTH WORKFORCE

Proposal: A national allied health data strategy and geospatial workforce dataset, as recommended in the 2020 National Rural Health Commissioner's Report, must move beyond distribution, supply and demand, and support the pursuit and evaluation of outcomes-focused and value-based changes in scopes of practice and models of care.

The Australian Institute of Health and Welfare (AIHW) would be best placed to develop and manage and allied health workforce minimum dataset, to better understand the rural allied health workforce.

RURAL AND REGIONAL ACCESS TO SERVICES

Proposal: Support is needed for implementing and embedding the Allied Health Rural Generalist (AHRG) Pathway across the three components of the Pathway. These are:

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.

Sustainability in implementing and embedding the Pathway as described in the Report would be achieved by:

- Building on existing structures to support funders, commissioners and service providers to implement cross-sector *Service and Learning Consortia*. This will enable collaboration between the Primary Health Network, Local Hospital Network, Aboriginal Community Controlled Health Services, University Departments of Rural Health, Rural Health Workforce Agencies and private providers. 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 through an accreditation system to support the AHRG pathway. Detailed planning work on an accreditation model has been undertaken by AHHA on behalf of Queensland Health; see https://www.health.qld.gov.au/__data/assets/pdf_file/0028/720496/ahha-accreditation.pdf This is an important component of the overarching AHRG pathway, including the Allied Health Rural Generalist Workforce and Education Scheme announced by Minister Coulton on 22 November 2019. Without investment in a formal accreditation program which brings together education organisations, professional groups and health service providers, the current funded arrangements are a continuation of previous training and business models which have failed to demonstrate positive outcomes.

- Subsidies for workforce training 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

AUSTRALIAN CENTRE FOR DISEASE CONTROL

Key recommendations:

- Establish an Australian Centre for Disease Control as a statutory body to provide national coordination and strengthen Australia's capacity to respond to new and re-emerging communicable diseases threats.

Opportunity: To provide national coordination of public health functions and services ensuring strategic, coordinated, and flexible, communicable disease prevention, detection and outbreak responses.

Context: In the wake of globalisation and the impacts of a changing climate, the threat of new and re-emerging communicable diseases is likely to be an ongoing global challenge. Australia is currently the only Organisation for Economic Co-Operation and Development (OECD) country that does not have a recognised authority responsible for communicable disease control.[i]

In 2013, a Standing Committee on Health and Ageing recommended the Australian Government commission an independent review to assess the case for establishing a national centre. Instead, the Government decided to work with the states and territories to develop and endorse a National Communicable Disease Framework, to achieve an integrated response without modifying the responsibilities of governments.[19]

The Australian Health Protection Principal Committee (AHPPC) is currently the peak expert committee for health emergency management and disease control, comprised of state and territory Chief Health Officers and chaired by the Australian Government Chief Medical Officer.

The 2020 COVID-19 pandemic revealed weaknesses in Australia's communicable disease planning and response processes. Inconsistent messaging and conflicting state and territory expert advice led the Australian Government to circumvent Australia's existing pandemic arrangements and establish a National Cabinet (comprising state, territory, and Australian government leaders).

National Cabinet provided an effective intergovernmental process to respond to an urgent public health need. However, while guiding Australian, state and territory government coordination, the implementation of the 'Cabinet-in Confidence' process has removed public transparency and oversight of crucial disease control decision-making processes.[20]

[19] Australian Government 2018, *Australian Government Response to the House of Representatives Standing Committee on Health and Ageing report: Diseases have no Borders: Report on the Inquiry into Health Issues across International Borders,* Canberra. Accessed 6 January 2021 https://www.health.gov.au/sites/default/files/response-diseases-have-no-borders.pdf

[20] Tulich, T, Reilly, B & Murray, S 2020, The National Cabinet: Presidentialised Politics, Power-sharing and a Deficit in Transparency, *Australian Public Law,* viewed 06 January 2021 https://auspublaw.org/2020/10/the-national-cabinet-presidentialised-politics-power-sharing-and-a-deficit-in-transparency/

Proposal: To prepare for the impacts of future disease outbreaks, epidemics and pandemics AHHA supports the establishment of an AusCDC as a statutory body. An AusCDC should:

- establish a cohesive and coordinated response across disease surveillance, research, technical advice and public messaging in Australia and the surrounding regions.
- be appropriately funded to fulfil a national coordination, advisory, capacity-building and research role while maintaining scope for regional response flexibility.
- be appropriately positioned to respond to a diverse range of threats both within Australia and beyond Australian borders.
- demonstrate global leadership in communicable disease planning and response capabilities.
- work collaboratively to ensure action undertaken in response to a communicable disease threats is reasonable, proportionate, equitable, informed by evidence and transparently considers the broad economic, social, and ecological impacts of implementation.
- protect the physical and mental health and safety of health professionals responding to current and emerging communicable disease threats.
- strengthen Australia's disease control evidence base.

A more comprehensive overview of the AHHA vision for an Australian Centre for Disease Control is available in the AHHA Australian Centre for Disease Control Position Statement.

CHILDREN'S MENTAL HEALTH

Key recommendations:

- Karitane be resourced to improve access across Australia to Internet-Parent Child Interaction Therapy (I-PCIT), a gold standard telehealth treatment intervention for young children with disruptive behaviour disorders. The Karitane I-PCIT service has a proven track record, having successfully delivered effective services in New South Wales since 2018, with rapid scaling during the Covid-19 pandemic.
- Resourcing should include support for workforce capacity building within Karitane, to enable service delivery across all states and territories of Australia.

Opportunity: To provide coordinated support to Karitane to deliver Parent Child Interaction Therapy (PCIT) via telehealth on a national scale.

Context: While some difficulty adjusting to parenthood is common and normal, severe and persistent problems can develop into chronic mental health concerns for parents and severe behavioural and conduct issues for children. Left untreated, these issues typically persist, putting the child at greater risk of developing severe and chronic behaviour and conduct disorders.[21,22] A behaviour disorder may be diagnosed when disruptive behaviours are uncommon for a child's age at the time, persist over time, or are severe. Disruptive behaviour disorders are diagnosed when child behaviours are severe, excessive in comparison to peers, and persistent over time. Disruptive behaviour disorders involve acting out and showing unwanted behaviour towards others (e.g., aggression), and so they are often called externalizing disorders. This kind of behaviour negatively impacts both the child and the people around them - putting stress on families, and making it difficult for the child to learn at school and make friends. This can lead to social and emotional difficulties or mental illness, and has been linked with eventual substance misuse and criminal activity.[23]

Services do exist in Australia to support parents and young children with disruptive behaviour disorders, but a number of significant access barriers persist, including:

- Regional families having to travel thousands of kilometres for specialist services
- Parents often struggling to take time off work and find childcare for siblings to attend treatment sessions
- Clinic-based support not being timely, often with long waitlists
- Not all of the interventions provided having a compelling evidence base.

Many of these barriers were further accentuated by the COVID-19 pandemic, which placed additional strain on families and made it harder for families to access face-to-face clinic intervention services.

[21] Campbell SB 1995, Behavior Problems in Preschool Children: A Review of Recent Research. The Journal of Child Psychology and Psychiatry, vol. 36, no. 1, pp. 113-149.
[22] Hemphill SA 1996, Characteristics of Conduct—Disordered Children and Their Families: A Review. Australian Psychologist, vol. 31, no. 2, pp. 109-118.
[23] Broidy LM et al 2003, Developmental trajectories of childhood disruptive behaviors and adolescent delinquency: A six-site, cross-national study. Developmental Psychology, vol. 39, no. 2, pp. 222-245.

New parents are typically young, digitally-savvy and seeking support services online. Existing online parenting services are patchy, yet the technology required is improving daily.

Proposed solution: Karitane is a leader in the delivery of high-quality perinatal infant & child mental health services in New South Wales, including delivery of a suite of telehealth services through its innovative Digital Parenting Hub. As part of this program, over the past two years Karitane has successfully implemented an Internet-Parent Child Interaction Therapy (I-PCIT) service for families living across NSW, in partnership with NSW Health.

We propose that Karitane be resourced to expand its I-PCIT service so that families from across all states and territories of Australia can access effective, evidence-based specialist treatment for young children with disruptive behaviours. The Karitane I-PCIT service has a proven track record, having successfully delivered effective services in NSW since 2018, with rapid scaling during the COVID-19 pandemic.

With funding support to expand their I-PCIT team to include an additional 15 FTE therapist positions, they will be able to deliver I-PCIT to over 1,000 families struggling with disruptive child behaviours from across Australia per annum.

Evidence base for PCIT: Karitane is internationally recognised as Australia's centre for excellence in the delivery of Parent Child Interaction Therapy (PCIT) for children aged 18 months to 5 years. PCIT is an evidence-based, gold standard treatment program. It uses live parent coaching to strengthen parent-child relationship quality and enhance parenting skills, typically through weekly sessions over a 3-4 month period. PCIT has been clinically proven to:

- treat severe persistent behaviour and conduct disorders in young children;
- improve parenting effectiveness, family functioning and social cohesion; and
- reduce symptoms of perinatal depression and anxiety, affecting at least 20% of new parents.

Decades of research studies show that PCIT dramatically improves child behaviour,[24] with clinically measurable positive effects still seen six years after therapy is completed.[25]

The figure below demonstrates the magnitude of PCIT outcomes, which have been found to be superior to other well-known evidence-based programs including Triple P, the Incredible Years, and Child-Centered Play Therapy. Effect size calculations allow researchers to ascertain the relative impact of interventions by examining the strength of the relationship between outcomes. A small effect is generally classified as ≥ 0.2, while a medium effect is ≥ 0.5, and a large effect is ≥ 0.8. The effect size for PCIT is 1.65, indicating an extremely large effect.

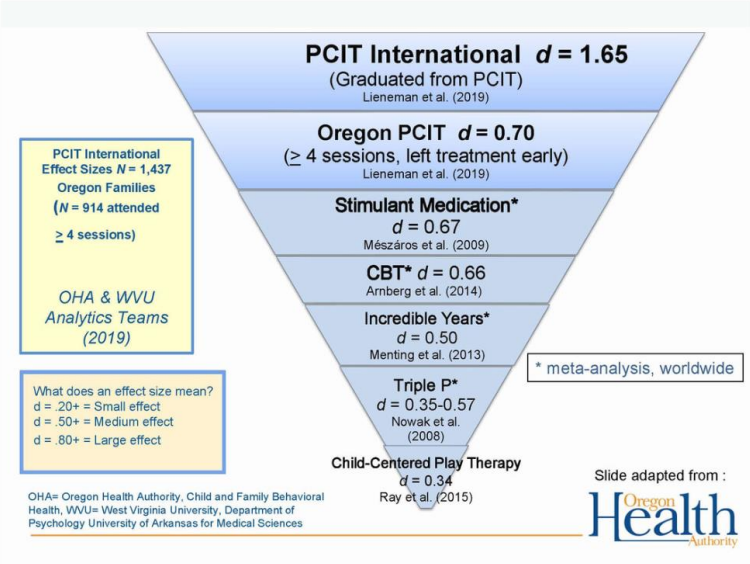
The impact of PCIT on families and wider society is also clear, with returns for society from PCIT calculated to be over US$15 per dollar invested.[26] These clinical and economic benefits, along with

[24] Ward, M.A., J. Theule, and K. Cheung, Parent-Child Interaction Therapy for child disruptive behaviour disorders: A meta-analysis. Child & Youth Care Forum, 2016. 45: p. 675-690.

[25] Hood, K.K. and S. Eyberg, M., Outcomes of parent-child interaction therapy: mothers' reports of maintenance three to six years after treatment. J Clin Child Adolesc Psychol, 2003. 32(3): p. 419-429.

[26] Washington State Institute for Public Policy, Parent-Child Interaction Therapy (PCIT) for families in the child welfare system. 2018: https://www.wsipp.wa.gov/BenefitCost/Program/77.

the known benefits and government commitment to early intervention,[27,28,29] highlight PCIT as a program clearly worth investing in.



The Karitane I-PCIT service: In I-PCIT, PCIT is delivered to families in their own homes via video-conference, rather than face-to-face at a physical treatment clinic. The feasibility and clinical effectiveness of I-PCIT has been demonstrated both internationally[30] and in the Karitane I-PCIT program.[31,32,33] Significantly, the Karitane I-PCIT service enables NSW families, particularly those in regional and remote areas, to access specialised, evidence-based child intervention services, regardless of where they live. The value of the Karitane I-PCIT clinic was particularly pertinent with the onset of the COVID-19 pandemic, when there was both increased demand for services and decreased capacity for face-to-face treatment modalities due to social distancing restrictions and enforced lock-downs.

As a model of care, the Karitane I-PCIT program is well aligned with the Australian Government Digital Health Strategy, COVID-19 response planning and the emerging National Children's Mental Health Strategy. Delivering I-PCIT nationally will significantly improve health and mental health service delivery to families with young children across Australia, providing tangible social and economic benefits across our communities. This is more important now more than ever with the mental health impacts of COVID-19. It will also increase interstate partnerships between parenting

[27] Teager, W., F. Fox, and N. Stafford, How Australia can invest early and return more: A new look at the $15b cost and opportunity. Early Intervention Foundation, The Front Project and CoLab at the Telethon Kids Institute, Australia. 2019: https://colab.telethonkids.org.au/siteassets/media-docs---colab/coli/how-australia-can-invest-in-children-and-return-more----final-bn-not-embargoed.pdf

[28] NSW Ministry of Health, The first 2000 days – conception to age 5 framework. 2019: https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2019_008.pdf

[29] Australian Government Productivity Commission, Mental Health (no 95). 2020: Canberra.

[30] Comer, J.S., et al., Remotely delivering real-time parent training to the home: An initial randomized trial of Internet-delivered parent-child interaction therapy (I-PCIT). J Consult Clin Psychol, 2017. 85(9): p. 909-917.

[31] Fleming, G.E., et al., An effectiveness open trial of Internet-delivered parent training for young children with conduct problems living in regional and rural Australia. Behavior Therapy, 2021. 52(1): p. 110-123.

[32] Kohlhoff, J., et al., Feasibility and Acceptability of Internet-Delivered Parent-Child Interaction Therapy (I-PCIT) for Rural Australian Families: A Qualitative Investigation. Rural and Remote Health, 2020. 20(1): p. 5306.

[33] Kohlhoff, J., et al., Internet delivered Parent Child Interaction Therapy (I-PCIT): two clinical case reports. Clinical Psychologist, 2019: p. 1-12.

support service providers to encourage better integrated care, promote and advocate for better digital care options for young families, and foster development of innovative evidence-based parenting support programs.

Karitane's Chief Executive leads the Australasian Association of Parent & Children's Health (AAPCH) and will foster strong interstate referral pathways to support an integrated continuum of care for families. This will link up services nationally in a way that has not been available before in child and family health. Access to parenting support should not depend on what state a family lives in. A strong referral network and nationally consistent online service delivery will ensure continuity of care and high quality support nationally.

Cost: Approximately $8 million over four years.

CLIMATE AND HEALTH

Key recommendations:

- A National Climate and Health Strategy should be developed and implemented that acknowledges environmental change, and the social and ecological determinants of health as key drivers of health system value, prevention, and improved outcomes.
- The Australian Government should provide coordinated, comprehensive and targeted funding to support research into the health impacts of climate change on health with emphasis given to vulnerable population groups.
- PHNs should be funded to develop evidence-based climate and health strategies tailored to the specific needs of their local communities.

Opportunity: To improve the health and wellbeing of Australians through targeted action to address the health impacts of climate change.

Context: The health of our planet is inextricably linked to human health.[34] With climate change set to disrupt the predictability of our environments, preventive action must consider the interconnected nature of inequality, health, and the ecological environment. Mitigating and adapting to climate change (and its drivers) will be key to reducing the disease burden and avoidable deaths and illness.[35]

NATIONAL COORDINATION

Proposal: AHHA, in conjunction with numerous other leading health and research organisations, support the development and implementation of a National Strategy on Climate and Health that:

- recognises planetary health, social and ecological determinants as key drivers of health system value and improved health outcomes;
- highlights the importance of preventive action, community capacity building and health promotion at the local level;
- recognises the interconnected nature of inequality, health and the environment; and
- identifies the many physical, emotional and social health co-benefits of action to reduce the human impact on climate.

The proposed Framework for a National Strategy on Climate, Health and Wellbeing,[36] developed by the Climate and Health Alliance in consultation with leading health and research organisations, should act as a basis for the development a National Climate and Health Strategy.

Climate and health must also be specifically addressed in the forthcoming preventative health strategy.

[34] Watts et al. 2020, 'The 2020 report of The Lancet Countdown on health and climate change: responding to converging crises', *The Lancet*, viewed 9 December 2020, https://doi.org/10.1016/S0140-6736(20)32290-X

[35] Climate and Health Alliance. (2018). Climate change is a health issue, Briefing Paper No.1. Viewed 15 September 2020. Available from: https://www.caha.org.au/briefing_papers

[36] Climate and Health Alliance 2017, *Framework for a National Strategy on Climate, Health and Well-being for Australians,* viewed 9 December 2020, https://www.caha.org.au/national-strategy-climate-health-wellbeing

RESEARCH

Proposal: The Australian Government must provide coordinated, comprehensive and targeted funding to support research into the health impacts of climate change with emphasis given to vulnerable population groups.

Research organisations, health networks and government agencies, and those relevant organisations beyond the traditional domains of health, need to be enabled to collaborate for cost-effective, long-term, longitudinal studies on the impacts of climate change on the physical, physiological and social domains that will affect public health. Research priority areas also need to be extended beyond the physical and mental health impacts of natural disasters. Health system capacity and resilience are a crucial area of research that also need to be made a priority.

To understand how the health system operates within the boundaries of preventing, preparing for, responding to, and recovering from climate related hazards and disasters the Australian Government should:

1. **Invest in the development and implementation of a health systems evaluation and resilience framework that can be used to:**

   - identify the direct and indirect effects of bushfire emergencies on health, health service delivery and health governance, including specific implications for communities returning directly to bushfire affected zones;
   - evaluate the preparedness of the health system and communities to respond swiftly and appropriately to new disasters;
   - plan for post-event recovery and health system resilience to climate and environment-related crises.

2. **Invest in data development that specifically considers the unmet need for:**

   - real time or more frequent data collections that gather and link data on human health and the climate and environment-related matters that are essential to determining causality, and monitoring trends and projections;
   - standardised clinical coding protocols and accurate coding of relevant conditions seen in hospital admissions, emergency department presentations, general practice and other primary care services that will be essential for health care planning, resource allocation and health systems resilience;
   - development of indicators to support national, state and regional performance reporting and service planning.

Through innovative and evidenced-based approaches we can move forward our understanding of the challenges that our health systems currently face and identify solutions that are more likely to address problems. It is crucial we ensure the evidence base required to respond to climate, environment and disaster related health challenges is strong, nationally consistent, and suitable both for service planning and future research efforts.

Cost: $5-7 million

PRIMARY CARE

Proposal: As part of a system wide approach, the Australian Government should support PHNs to capitalise on their existing infrastructure, networks, and leadership to build the capacity of the primary care sector to mitigate and prevent the impacts of climate change on health and wellbeing.

The Australian health sector contributed to 7.2% of Australia's total carbon emissions in 2014-15, with hospitals and pharmaceuticals the major contributors.[37] Primary care can play a key role in reducing the overall health sector carbon footprint through direct action to lower its own emissions contribution, but possibly more significantly indirectly by decreasing Australia's reliance on hospital-based health care. The primary health care sector also plays a role in building the resilience of communities, anticipating their climate risks, mitigating the impacts of climate change on health and wellbeing and strengthening the system's resilience and adaptive capacity to climate-related hazards and disasters. Globally, however, there are few examples of strategic approaches in primary health care.

In 2020 AHHA worked with Sydney North Health Network to develop a Climate and Health Strategy that aligned with the SNHN strategic plan providing contextual information, strategies, actions, measures of success, and an approach for monitoring progress on issues of climate and health within the Sydney North region.

AHHA recommends this type of strategic approach be replicated across Australia with all PHNs supported to engage with their local communities on issues of climate and health and think strategically about how to address the short and long term impacts of climate on health within their region.

Targeted funding is needed to enable all 31 PHNs across Australian to develop evidence-based climate and health strategies tailored to the specific needs of their local communities.

Cost: $960,000. $32,000 per PHN.

[37] Malik, A., Lenzen, M., McAlister, S & McGain, F 2018. The Carbon footprint of Australian healthcare, vol.2, no. 1,viewed 22 January 2021 https://www.thelancet.com/journals/lanplh/article/PIIS2542-5196(17)30180-8/fulltext

DISASTER AND EMERGENCY MANAGEMENT

Key recommendations:

- The role of primary care should be well defined and clearly incorporated into current and future disaster and emergency prevention, preparedness, response and recovery processes.
- PHNs should be authorised by national and state and territory governments, and recurrently funded, to coordinate regional primary healthcare responses before, during and after natural disasters and emergencies.

Opportunity: To ensure a whole-of-system integrated disaster and emergency prevention, preparedness, response and recovery effort.

Context: The extraordinary circumstances of 2020 have highlighted the important role that should be held by primary care providers and Primary Health Networks (PHNs) during times of crisis. Primary health care is an important part of Australia's healthcare system but while there is much goodwill and commitment from primary care providers, to date the role of GPs and primary care have not usually been included at all in disaster and emergency planning processes. This leaves the healthcare system vulnerable to reactive, on the run emergency and disaster responses built on a foundation of sub-optimal coordination. The COVID-19 pandemic and 2019-20 bushfire disaster have highlighted this with ineffective planning and mechanism for coordination contributing to system inefficiencies, fragmentation, and the delivery of sub optimal community care in some areas.[38]

Although national and state agencies have the overall responsibility for on-the-ground disaster management[39], during natural disasters or health emergencies PHNs offer the opportunity to coordinate a strong primary health care response that will deliver care where and when it is needed, reducing pressure on the acute sector and ensuring an integrated response. PHNs have developed unique insights into their communities and healthcare provision at a local level. As part of their integration role, PHNs have developed expertise in working across systems and sectors.

The Royal Commission into National Natural Disaster Arrangements Report recommended that "Australian, state and territory governments should develop arrangements that facilitate greater inclusion of primary healthcare providers in disaster management, including: representation on relevant disaster committees and plans and providing training, education and other supports" (Recommendation 15.2: Inclusion of primary care in disaster management).[40]

[38] Australian Government. *2020 Royal Commission into National Natural Disaster Arrangements- Report*. Viewed 7 January 2021 https://naturaldisaster.royalcommission.gov.au/publications/royal-commission-national-natural-disaster-arrangements-report

[39] Australian Government 2017. *COMDISPLAN Australian Government Disaster Response Plan*. Viewed 7 January 2021 https://www.homeaffairs.gov.au/emergency/files/plan-disaster-response.pdf

[40] Australian Government. *2020 Royal Commission into National Natural Disaster Arrangements- Report*. Viewed 7 January 2021 https://naturaldisaster.royalcommission.gov.au/publications/royal-commission-national-natural-disaster-arrangements-report

Proposal: The role of primary care in disaster and emergency preparedness must be well defined and clearly incorporated into current emergency preparedness to create one overall integrated system where each party knows the roles and chain of command so that during a natural disaster or emergency, agreed responses are ready to be enacted.

For this to be achieved:

- the role of primary care and PHNs in disaster and emergency management must be recognised and supported by all levels of government (local, state/territory and national) and relevant stakeholders.
- PHNs must be authorised and recurrently funded to coordinate regional primary healthcare responses before, during and after natural disasters and emergencies, as part of the overall health emergency response
- PHNs should be included as key agencies in national, state and regional health emergency preparedness and response plans with clear, formalised roles and responsibilities. Adequate PHN and primary care representation on relevant planning and preparedness committees is essential.
- PHNs and primary healthcare providers must be funded to undertake regional emergency planning and preparedness work, including developing primary health preparedness and response plans, and related communication, training and trialling.
- mechanisms to remunerate primary care providers for time delivering care outside of their usual premises and systems to manage aspects such as professional indemnity insurance must be developed.

Cost: $21.7m over a 3-year period for PHNs to be adequately resourced (with additional surge capacity funding as required depending on need).

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.

IMPROVING ACCESS TO MEDICINES

Opportunity: To improve access to medicines for Aboriginal and Torres Strait Islander people when discharged from hospital.

Context: Aboriginal and Torres Strait Islander people are less likely than non-Indigenous people to access 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.[41]

Patients not taking their medicines after discharge from hospital is a major problem resulting in poor health, clinical deterioration, re-hospitalisation and death. Acute separations and emergency department attendances present an opportunity to improve access to medicines.

All states and territories, except NSW and ACT, are participating in the Public Hospital Pharmaceutical Reforms that enables hospitals to prescribe and dispense PBS subsidised medicines to 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.

Proposal: The CTG PBS Co-Payment measure be applied when medicines are dispensed from public hospitals to improve medicines access by Aboriginal and Torres Strait Islander people living with or at risk of chronic disease. This would address a range of barriers to accessing needed medicines faced by patients including out-of-pocket costs, transport to community pharmacies and accessibility of community pharmacies upon 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 additional PBS medicines being dispensed. Rather, it would address the under-utilisation of current CTG support in the community.

Cost: 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 also to participate, the total re-direction of funds is estimated to be an additional $6.7 million.

[41] 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.

MENTAL HEALTH

Key recommendations:

- The Australian Government should take immediate steps to enable system reforms for those suffering from mental ill-health within the priority areas identified by the Productivity Commission of governance and accountability; regional planning, decision making and commissioning; and monitoring evaluation and research.
- Joint funding and planning at the local level for mental healthcare services should be between Primary Health Networks, Local Hospital Networks or equivalent, and community service providers.
- Long term reform should ensure implementation of funding models that prioritise value and address social, cultural, and ecological determinants of health.
- Structures must be embedded that support the equitable implementation and uptake of innovative virtual solutions and digital platforms that augment and support in person mental health care.

Opportunity: To accept and implement the recommendations of the Productivity Commission (PC) inquiry final report on Mental Health, that identifies the need for wide scale structural system wide mental health reform to improve mental health outcomes and stimulate economic efficiencies.[42]

Context: Mental ill-health affects all Australians either directly or indirectly with nearly one in five Australian experiencing mental ill health in a given year.[43] Evidence shows that Aboriginal and Torres Strait Islander people, younger generations and people living in rural and remote locations experience a higher burden of mental ill health.

The PC inquiry final report on Mental Health has identified significant gaps in access to mental health care within Australia. The over 1500-page report demonstrates the extreme complexity of the current system and the barriers preventing many Australians from receiving the mental health support they need when they need it. Many of the reforms recommended by the final Productivity Commission Inquiry Report have been proposed before and are therefore familiar to governments, providers and those harmed by inadequate mental healthcare services.

The PC Inquiry report also highlights the potential economic benefits of reform including quality of life improvements valued at up to $18 billion annually, and an annual benefit of up to $1.3 billion from increased economic participation.[44]

There is a growing body of evidence demonstrating the intrinsic link between mental health, the environment, and our changing climate. The rising prevalence of eco anxiety and the mental health

[42] Productivity Commission. 2020. Productivity Commission Inquiry Report Mental Health, Report no. 95, Canberra. Available at https://www.pc.gov.au/inquiries/completed/mental-health/report
[43] Ibid
[44] ibid

impacts of climate related hazards and disasters (e.g., bushfires, pandemics, drought, heat stress) is of significant short- and long-term mental health concern. [45]

The social, economic and health conditions created by COVID-19 have further compounded the need for national mental health investment and reform. Job insecurity and social isolation have, and will continue to have, significant impacts on both individuals and the overall mental health system, increasing the number of Australians in need of support.[46] Since the beginning of the pandemic mental health telephone support services have reported the demand for services increasing by approximately 30 percent[47] and modelling reveals a 'best case scenario' of a 13.7 percent increase in suicide deaths in the wake of COVID-19.[48] If Australia's mental health system is to be prepared to respond to unprecedented current and future challenges, action must be an immediate budget priority of the Australian Government.

Proposal: The Australian Government should initiate immediate steps to enable meaningful system reform for those suffering from mental ill-health. Immediate priority must be given to reforms in the areas of governance and accountability; regional planning, decision making and commissioning; and monitoring, evaluation and research as outlined in the AHHA Response to the Australian Government consultation on the recommendations from the Productivity Commission Inquiry Report on Mental Health.

The 2020-25 Addendum to the National Health Reform Agreement outlines a commitment for the Australian Government, states and territories to 'work in partnership to implement arrangements for a nationally unified and locally controlled health system which will improve local accountability and responsiveness to the needs of communities, through continued cooperation and collaboration between Local Hospital Networks (LHNs) and Primary Health Networks (PHNs)' (Schedule E) (CFFR 2020). AHHA ongoing support for this recommendation is highlighted in *Healthy people, healthy systems: A Blueprint for outcome focused, value-based healthcare.* [49]The introduction of levers and accountability structures that strengthen the role of existing organisational structures (PHNs and LHNs), is a cost-effective strategy that delivers on this intention of governments and recognises the interconnected nature of mental and physical health.

In the long-term, reform should focus on reorienting the mental health system through the implementation of integrated value-based healthcare approaches that prioritise support across the broad spectrum of social, cultural and ecological determinants of health. A climate and health lens must be applied over all elements of mental health reform. Existing social and cultural inequalities

[45] Ingle, H & Mikulewicz, M 2020, Mental health and climate change: tackling invisible injustice, *The Lancet Planetary Health,* viewed 15 December 2020 https://www.thelancet.com/journals/lanplh/article/PIIS2542-5196(20)30081-4/fulltext

[46] Purtill, J. 2020. Victoria shows coronavirus is a pandemic of casual, insecure work, *ABC*. Viewed 25 September 2020. Available from: https://www.abc.net.au/triplej/programs/hack/coronavirus-covid-19-outbreak-linked-to-casual-insecure-work/12496660

[47] Ponniah, S., Angus, D. and Babbage, S. (2020). Mental health in the age of COVID-19. Viewed 25 September 2020. Available from: https://www.pwc.com.au/health/health-matters/why-mentalhealth-matters-covid-19.html

[48] Atkinson, J., Skinner, A., Lawson, K., Song, Y. and Hickie, I. (2020). Road to Recovery; Restoring Australia's Mental Health, The University of Sydney Brain and Mind Centre. Viewed 25 September 2020. https://www.sydney.edu.au/content/dam/corporate/documents/brain-andmind-centre/road-to-recovery_brain-and-mind-centre.pdf

[49] Australian Healthcare and Hospitals Association (AHHA). 2020. Health people, healthy systems. Available at https://ahha.asn.au/Blueprint.

such as job insecurity, discrimination and social isolation, recently exacerbated by COVID-19, must be considered and addressed in the design and reform of the mental health system.

Integrated ways of working need to become embedded within health systems with structures implemented to bolster the delivery of a suite of multidisciplinary, cross sector services centred around the unique needs and circumstances of individuals. Alignment is also needed across the breadth of government health reform strategies to ensure focused, coordinated action that improves the long-term physical and mental health of Australians. Consumer engagement and co-design will be critical to ensure alignment, develop new models of care and embed workforce structures centred around the needs of patients.

Enhancing mental health digital capability should also be an aim of governments, with the capacity to enabled enhanced provision of care, particularly in rural communities. The announcements in the wake of COVID-19 of MBS funding for telehealth is a great first step but further improvements are needed to ensure systematic integration of virtual technologies and capabilities long term. Provisions for allied health professionals and specialists to charge out of pocket costs for MBS funded telehealth have a negative impact on equity for mental health consumers. Likewise, the requirements related to an existing GP relationship (and potentially voluntary patient registration) may serve as a significant barrier to care for some mental health consumers.

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.
- Funding allocations that reflect the cost of providing care in rural and remote areas, smaller jurisdictions and to groups with higher needs.
- 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.
- $50 million over the next three years to fund water fluoridation infrastructure.
- Actively promote the Child Dental Benefits Schedule to eligible families.
- Treble the number of scholarships for Aboriginal and Torres Strait Islander dental students.
- Capital investment for every dental school to have a teaching clinic in a local AMS.
- 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.

Opportunity: 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.

Context: 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. Despite improvements over the last 20–30 years, there is still evidence of poor oral health among Australians[50]. Oral conditions are the fourth highest reason for potentially preventable hospital admissions with more than 70,000 Australians hospitalised in 2016-17[51]. Out-of-pocket costs for dental care are also greater than any other major category of health spending.

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 and residential aged care facilities also have more difficulty accessing oral healthcare. 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 areas[52]. In small towns this has widened, despite improved national averages, since 1981[53].

[50] 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.

[51] Australian Institute of Health and Welfare (AIHW) 2019. Potentially preventable hospitalisations in Australia by age groups and small geographic areas, 2017-18, Cat. No HPF 36, Canberra: AIHW

[52] 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.

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

PUBLIC DENTAL TREATMENT

Proposal: Funding of $500 million per year is needed for the National Partnership Agreement (NPA) on Public Dental Services (NPAPDS) with state and territory government funding levels maintained to improve access to and affordability of dental care. The term of the agreement should be extended to 31 December 2024 to align with the term of the Child Dental Benefits Schedule.

A series of reductions to the funding for both the National Partnership Agreement on Public Dental Services for Adults and the Child Dental Benefits Schedule (CDBS) have occurred since the 2014-15 Budget. The 2018–19 Mid-Year Economic and Fiscal Outlook provided a one-year extension to the funding of the NPAPDS, to 30 June 2020. The NPAPDS was again extended in 2020 for another 12 months to 30 June 2021.

The reduction in Australian Government funding to the states and territories for oral health 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.

Cost: $500 million per year.

PREVENTION

Proposal: The Australian Government should provide national leadership by working with state and territory governments to ensure fluoridation of all reticulated water supplies in Australia.

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 adults[54]. Nearly 3 million Australians do not have a fluoridated water supply[55].

For example, in Queensland more Aboriginal and Torres Strait Islander people live in areas that either did not implement fluoridation or ceased fluoridation after 2012. As a consequence, about 50 per cent of Aboriginal and Torres Strait Islander people in Queensland do not have access to fluoridated water, although the access rate for the total Queensland population is around 76 per cent[56].

AHHA supports a linkage between national funding of dental services, through the NPA, and the extent of state and territory water fluoridation programs. The Australian Government should require states and territories to establish and maintain a minimum 90 per cent of the population has access to fluoridated water.

Cost: $50 million for capital works to assist with the development of water fluoridation infrastructure.

[54] 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.

[55] 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.

[56] AMA 2019, *2019 AMA Report Card on Indigenous Health*, Australian Medical Association, Canberra, viewed 3 December 2019, https://ama.com.au/system/tdf/documents/2019%20AMA%20Report%20Card%20on%20Indigenous%20Health_0.pdf?file=1&type=node&id=51639.

BARRIERS TO TREATMENT

Proposal: The Australian Government should better promote the CDBS to the families of eligible children. Better reporting and analysis of CDBS data will 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.

Out-of-pocket cost to individuals is acknowledged as a major barrier to appropriate and regular dental care. More than 30% report that they avoid or delay visiting a dentist due to cost[57]. 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.

DENTAL WORKFORCE

Proposal: Additional Australian Government support is required to promote the entry of Aboriginal and Torres Strait Islander people into the dental workforce. Capital investment by the Australian Government is needed for every dental school to have a teaching clinic in a local Aboriginal Medical Services (AMS).

More Aboriginal and Torres Strait Islander dental practitioners are needed. The leading financial support for these students, the Puggy Hunter Memorial Scholarship (PHMS) hasn't been increased in ten years and there are more than twice as many dental applicants than scholarships available.

The ability of non-Indigenous dental practitioners to deliver culturally safe care for Aboriginal and Torres Strait Islander patients depends upon their undergraduate education as well as regulatory requirements through the Australian Health Practitioner Regulatory Agency (AHPRA). However, this is compromised because most dental schools do not have sufficient access to teaching placements with an AMS.

[57] 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.

PREVENTIVE HEALTHCARE

Key recommendations:

- Increase preventive health funding to 2.3% of recurrent expenditure on health.
- Commit resources to support needs assessments and public health capacity at the regional level allowing for the implementation of national, regional and local prevention and health promotion agendas, adjusted to suit the specific needs of the local communities, e.g. the mass roll out of COVID-19 vaccination.
- Ensure the forthcoming National Preventive Health Strategy addresses climate change and the social, ecological and cultural determinants of health in addition to biological and behavioural risk factors; and data and technology development.
- Adopt a 'Health in All Policies' and cross portfolio prevention approach to ensure shared responsibility and accountability for the success of prevention initiatives. Leadership should sit within health with all relevant portfolios included in implementation and decision-making processes (e.g. in social services, education, environment, mental health, transport, infrastructure, energy, population, cities, agriculture and regional development).
- Recognise the rapid developments occurring in technology and data, and capitalise on these opportunities to revolutionise, not just mobilise, preventive health.
- Develop a primary health care national minimum dataset to inform a better understanding of population health and opportunities to mobilise preventative action.
- Invest in evidenced-based strategies to discourage the consumption of sugar-sweetened beverages, including introduction of a 20% ad valorem sugar-sweetened beverages tax, with revenue hypothecated for preventive health measures.
- Implement a five-year transition period to shift from voluntary to mandatory implementation of the Health Star Food Rating System.

Opportunity: To invest in a range of preventive health initiatives to reduce illness, prevent disease and promote wellness.

Context: Australia spends less on public health and preventive care than most other OECD countries.[58] The increasing burden of chronic disease within Australia intensifies the need for investment in evidence based preventive health strategies. This is reinforced by Australia's commitment to the 2025 WHO global targets to reduce premature mortality from the four major non-communicable diseases: cardiovascular disease, cancer, chronic lung diseases and diabetes.[59]

A person's healthcare should extend beyond immediate presenting concerns to take a broader view of their health and wellbeing. Such an approach requires consideration of physical, mental, ecological and social wellbeing, which is influenced by individual, lifestyle, environment and cultural factors;

[58] Organisation for Economic Cooperation and Development (OECD) 2017, *OECD.Stat: Health expenditure and financing*, viewed 25 November 2017, http://stats.oecd.org/Index. aspx?DataSetCode=SHA

[59] World Health Organization (WHO) 2013, *Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013-2020*, World Health Organization, Geneva, viewed 25 November 2017, http://www.who.int/nmh/ publications/ncd-action-plan/en/

socioeconomic conditions; and access to quality health care programs and services. This requires a preventive approach to healthcare, supported by targeted investment by government.

Health should be seen as an investment, not just a cost. As reinforced by the Productivity Commission, there is a strong rationale for a greater emphasis on public health and prevention in an integrated system[60], with expenditure on such measures contributing to Budget repair by reducing future demand on the health system while simultaneously improving health outcomes and quality of life for all Australians. This is also consistent with the fourth Intergenerational Report highlighting the pressure that health costs will place on the Australian Government budget[61]and objective 1 of the National Strategic Framework for Chronic Conditions[62], which is 'to focus on prevention for a healthier Australia'. [63]

The announcement of Australia's Long Term National Health Plan, including the development of a 10-year National Preventative Health Strategy (the Strategy) outlines a national commitment to preventative health. In addition, the Heads of Agreement on public hospital funding and health reform for 2020-2025 outlines a commitment to progress reforms to promote health literacy, prevention and well-being (clause 7c).

FUNDING

Proposal: Australia spends less on public health and preventive care than most other OECD countries. Peaking at 2.3% of recurrent expenditure on health in 2007- 08, Australia's prevention spending fell to 1.6% in 2017-18. Comparatively, most OECD countries spend between 2% and 4% of total health expenditure on prevention.[64] AHHA proposes a return to 2.3% of recurrent health expenditure is initially targeted, to be progressively increased over a 5-year period to reach at least 4% of recurrent expenditure. A dedicated focus on ensuring spending is on activities with demonstrated cost-effectiveness[65] and which interpret lifestyle choices in the context of the opportunity costs and other incentives faced by individuals, will be critical to maximising value.[66]

[60] Productivity Commission 2017, *Shifting the Dial: 5 year productivity review*, Productivity Commission, viewed 19/11/2019, https://www.pc.gov.au/inquiries/completed/productivity-review/report.

[61] Treasury 2015, *2015 Intergenerational report: Australia in 2055*, Australian Government, Canberra, viewed 1 November 2017, https://treasury.gov.au/publication/2015- intergenerational-report/

[62] AHMAC 2017, *National Strategic Framework for Chronic Conditions*, Australian Health Ministers' Advisor y Council, viewed 19/11/2019, https://www1.health.gov.au/internet/main/publishing.nsf/Content/nsfcc.

[63] Australian Health Ministers' Advisory Council (AHMAC) 2017, *National Strategic Framework for Chronic Conditions*, Australian Government, Canberra, viewed 1 November 2017, www. health.gov.au/internet/main/publishing.nsf/ content/nsfcc

[64] Gmeinder, M., Morgan, D. and Mueller, M. (2017). OECD Health Working Papers No. 101 - How much do OECD countries spend on prevention? Viewed 15 September 2020. Available from: https://www.oecd-ilibrary.org/docserver/f19e803cen.pdf?expires=1600140514&id=id&accname=guest&checksum=16D88668D16F89A31E3D72ED42C 15393

[65] Jackson, H & Shiell, A 2017, *Preventive Health: How Much Does Australia Spend and Is It Enough?* Canberra, Foundation for Alcohol Research and Education; World Health Organization (WHO) 2014b, *The Case for Investing In Public Health - Strengthening Public Health Services and Capacity: A Key Pillar of the Europe Regional Health Policy Framework, Health 2020,* WHO, Geneva, viewed 25 November 2017, http://www.euro.who.int/en/health-topics/ Health-systems/public-health-services/ publications/2015/the-case-for-investing-inpublic-health

[66] Sassi, F & Hurst, L 2008, *The Prevention of Lifestyle-Related Chronic Diseases: An Economic Framework*. OECD Health Working Papers No 32, OECD, Paris, viewed 25 November 2017, https://www.oecd.org/els/ health-systems/40324263.pdf

Funds dedicated to prevention activities must be based on regional need. A collaborative approach is required between the Australian, state and territory governments to establish consistent governance arrangements between Primary Health Networks (PHNs) and Local Hospital Networks (LHNs) or equivalent for shared regional needs assessments, priority setting and funding. This will support delivery of preventive healthcare that is coordinated, integrated and responsive to local need.

The Voluntary Patient Enrolment initiative in general practice, anticipated for implementation in 2021, provides an opportunity for exploring funding models for preventative health initiatives in primary care that focus on value for individuals and the population.

DETERMINANTS OF HEALTH

Proposal: The health of individuals and communities is influenced significantly by the social determinants of health – factors such as housing, income, education, conditions of employment, power distribution and social support – and these require greater emphasis within preventative policy. For Aboriginal and Torres Strait Islander people, cultural determinants are important, with the need to strengthen languages, relationships, cultures, identity, place and networks for rebuilding resilience and cultural sustainability.[67]

The COVID-19 pandemic has further highlighted the dependency of preventive health on social, cultural and ecological determinants. Overcrowded, informal or no housing has exposed people to increased risk of infection.[68] Unstable finances, casual employment, limited access to the internet and low literacy has impacted the ability of individuals to respond to self-isolation protocols during a public health crisis, increasing spread of infection.[69]

A national preventative approach should prioritise a strengths-based approach, where the self-determination and strengths of individuals and communities are emphasised. Successful adoption of such an approach has been demonstrated across aged care, at-risk families, Aboriginal and Torres Strait Islander people and more. People need to be seen as more than just their care needs, rather to be viewed first as experts and in charge of their own lives. Such an approach focuses on the strengths, skills and resources of individuals and communities, recognising their autonomy, and empowering choices and solutions right for them

In the AHHA Submission to the Consultation Paper for the National Preventive Health Strategy the need to promote integration and collaborative action that addresses the broad determinants of social, cultural and ecological health is highlighted in greater detail.

[67] Lowitja Institute. (2014). Cultural determinants of Aboriginal and Torres Strait Islander health roundtable. Viewed 16 September 2020. Available from: https://www.lowitja.org.au/page/research/research-roundtable/cultural-determinants

[68] Gurran, N., Phibbs, P. and Lea, T. (2020). Homelessness and overcrowding expose us all to coronavirus. Here's what we can do to stop the spread, The Conversation. Viewed 15 September 2020. Available from: https://theconversation.com/homelessness-and-overcrowding-expose-us-allto-coronavirus-heres-what-we-can-do-to-stop-the-spread-134378

[69] O'Sullivan, D., Rahamathulla, M. and Pawar, M. (2020). The impact and implications of COVID-19: an Australian perspective, The International Journal of Community and Social Development, vol. 2(2). DOI: 10.1177/2516602620937922

NATIONAL COORDINATION

Proposal: To be effective, prevention policy and action cannot be health portfolio-centric. There needs to be accountability and inclusion across all portfolios, including social services, education, environment, mental health, transport, infrastructure, energy, population, cities, agriculture and regional development.

Alignment across the various national health strategies that are currently in development must also be ensured including the National Health Reform Agreement, the 10-year Primary Health Care plan, condition-specific plans (the Mental Health and Suicide Prevention Plan), population-segment plans (National Men's Health Strategy, National Women's Health Strategy, the National Action Plan for the Health of Children and Young People), disaster and emergency preparedness plans, and emissions-reducing targets and plans.

DATA AND TECHNOLOGY

Proposal: The COVID-19 pandemic has revealed the many ways technology and data can be used to protect health, including contact tracing apps, temperature sensing drones, apps to monitor social distancing and facial recognition surveillance. Governments must recognise and capitalise on the opportunities that technology and data provide in mobilising a prevention system.

Artificial intelligence (AI) offers promising opportunities to improve health through preventive rather than reactionary measures. It has the ability to collect, compile, analyse and learn from big data, augmented by real-time data from patients, and create personalised and predictive feedback for individuals. It can improve diagnostics, catalyse patient adherence through engagement, and integrate with remote monitoring devices, all directly influencing the behaviour of patients and improving preventive health action.

However, the ethical challenges of AI must also be considered. Care must be taken to ensure existing biases and inequalities are not exacerbated with the use of AI, rather it is used to correct disparities.[70] Public data privacy concerns must also be addressed. Ethical collaboration within the Australian health care sector will be crucial to seeing this action achieved.[71]

Greater access to Primary health care data can enable a proactive approach to preventive health care by providing clinicians with data about local populations, individuals in their care, and a directory to social care and other locally available supports. However consolidated primary health care data in Australia is poor. While individual providers of primary health care hold significant amounts of information on the services provided to patients, the conditions for which they are being treated, and the progression of patients' recovery or further deterioration of their condition, there is currently no consolidated data source that allows for national benchmarking and quality improvement within the primary health sector.

[70] Chen, I., Joshi, S. and Ghassemi, M. (2020). Treating health disparities with artificial intelligence, *Nature Medicine*, vol. 26, pp. 16-17. DOI: 10.1038/s41591-019-0649-2

[71] Australian Consensus Framework for Ethical Collaboration in the Healthcare Sector. (2018). A Consensus Statement of Shared Values and Ethical Principles for Collaboration and Interaction Among Organisations in the Healthcare Sector. Viewed 16 September 2020 https://ahha.asn.au/sites/default/files/docs/policyissue/acf_september_10_2018_w_apec_web.pdf.

The development of a primary health care national minimum dataset, that provides common data standards and reporting frameworks, is therefore necessary to consolidate the various primary care data sources, inform population health planning, and enhance the implementation of evidence-based value-driven prevention programs.

Further investments in physical infrastructure, data enablement, IT architecture, workforce development and the development of local models of care, are also needed. The long-term health reform principles identified in the National Health Reform Agreement addendum that provide for joint planning and funding at a local level and paying for value and outcomes,[72] mean that Primary Health Networks (PHNs) are well-placed to reorientate primary health care towards prevention. However, they must be given the authority and resources to do so and be enabled by national infrastructure and policies.

[72] Council of Federal Financial Relations 2020, *Addendum to the National Health Agreement 2020-2025*, viewed 10 November 2020, http://www.federalfinancialrelations.gov.au/content/npa/health/other/NHRA_2020-25_Addendum_consolidated.pdf

PRIVATE HEALTHCARE

Key recommendations:

- The Productivity Commission should be directed to conduct an independent comprehensive review of government support for private healthcare in Australia.
- This independent review should assess the value to the Australia community, and the impact on the public health system, of government support of private healthcare through subsidies and other policies.
- This review should assess the most effective ways that the Australian Government can support private healthcare, such that it complements and does not compromise the integrity of Australia's universal healthcare system, Medicare.

Opportunity: Private healthcare in Australia is supported by a range of government subsidies and other policies. The value to the Australian community of these supports needs to be assessed to ensure that the most effective and efficient balance between public and private healthcare services is being achieved.

Context: Australia's mixed public-private health system is entrenched. In 2017–18, 68.3% of all health expenditure was funded by Commonwealth, state and territory governments, which includes services provided by both public and private providers.[73] A wide range of other government policies are also in place that influence the provision of private healthcare including:

- the defining of privately-provided services and products that are funded publicly (e.g. the MBS item descriptors and subsidies, the PBS, the Community Pharmacy agreements, the Child Dental Benefits Schedule, requirements for referral to specialists) and through private health insurance (e.g. the Prostheses List);
- programs affecting safe and quality care (e.g. limitations on professional scopes of practice, individual professional registration, credentialing requirements, provider accreditation requirements, the Practice Incentive Program in general practice);
- programs affecting access (e.g. rural incentive programs, pharmacy ownership and location rules, education and clinical training standards and support);
- incentives for private health insurance (e.g. the Medicare levy surcharge, the private health insurance rebate, lifetime health cover); and
- regulation of products (e.g. patents, scheduling of medicines, advertising restrictions).

Proposal: Australia will always have a need for the availability and provision of private healthcare. However, the manner in which government should and should not support private healthcare needs to be clearly articulated, including the public benefits any such support provides and assurance that it does not compromise equitable access.

There should be an independent comprehensive review by the Productivity Commission of the public policy objectives that are served by Government support of private healthcare and private health insurance. This should assess the value to the Australia community, and the impact on the public health system, of government support of private healthcare through subsidies and other policies.

[73] https://www.aihw.gov.au/getmedia/91e1dc31-b09a-41a2-bf9f-8deb2a3d7485/aihw-hwe-77-25092019.pdf.aspx Viewed18 December 2019.

SPECIALIST REFERRALS

Key recommendations:

- Conduct an independent, evidence-based review of the specialist referral system, informed by the development and implementation of a national strategy for capturing and reporting standardised specialist referral-related metrics.
- Amend specialist referral rules to:
    - decouple specialist billing from referral status and introduce protections to prevent increased costs for patients under long-term specialist care.
    - expand health professional referral rights and adoption of a linear evidence-based model of patient transfer through the health system to optimise use of the health workforce.

Opportunity: A health service model that places a greater emphasis on the appropriateness of referrals above the profession of the referrer is necessary to bring referral rules in line with contemporary health needs and service structures.

Context: The specialist referral system is a key operational component of the Australian health system. It is designed to manage access to subsidised specialist services and remunerate MBS Providers at referred service rates. The regulatory requirement for patients to obtain repeat referrals when already under the care of a specialist has received limited scrutiny since the 1970s—a time when acute, not chronic, illnesses were more common and the need to be supported by numerous specialists over the long term was less likely.

The rise of chronic illnesses and multimorbidity highlights fundamental inefficiencies in the referral system, as more patients require long-term specialist care beyond standard 3-and-12-month periods of referral validity. The expiration of a referral while a patient is receiving ongoing specialist care has created a rigid structure of patient health-service transition that is increasingly contrary to evidence-based health care.

Referral expiration means patients must obtain a repeat referral in order to maintain access to their MBS subsidised specialist care, which is most commonly from a GP (General Practitioner). This exposes patients to increased out-of-pocket costs and risks delayed or discontinued medical treatment. As referrals are inherently related to MBS billing practices, excessive health service utilisation under the referral system negatively impacts the ability to offer equitable and durable health services within the wider health system.

The ‘gatekeeper’ role of GPs in patient care is reinforced by legislation framing the referral system. However, GP engagement through referral expiration is a model that is based on opportunistic rather than purposeful clinical engagement.

Proposals:[74] The limited data on how patients transition through the health system undermines effective service design. A national strategy for capturing and reporting standardised referral metrics is needed to inform evidence-based legislation and care. To be beneficial, this strategy needs to reflect referral trends across all sectors including public and private service providers.

Including referral related metrics into the Primary Health Care Data Asset will improve knowledge gaps, however this also needs to be supported by an in-depth understanding of longitudinal trends in health service utilisation including tertiary related referral activities. A greater investment in linked data by government is therefore needed to ensure patient health service transition is adequately mapped and evaluated.

An in-depth independent review of the health and economic costs and benefits of the referral rules, and associated MBS billing practices should be undertaken to ensure the rules that underpin referral practices are evidence-based, patient-centred and appropriate to support the changing health needs of the nation.

The expiration of a referral is broadly incompatible with the aims of specialist care for people with long-term illness. There is a need to decouple specialist billing more broadly from referral status to ensure consultations are based on clinical need. Indefinite referrals should be issued to ensure patients under long-term specialist care are not adversely and routinely impacted by referral expiration.

Reducing the number of transition points a patient must navigate through the health system by introducing and expanding the referral rights of non-GP clinicians is important for promoting health system efficiency. Expanding the referral rights, including periods of referral validity, for current and presently non-recognised clinicians under the MBS referral rules will maximise the skills of the diverse health workforce and reduce the frequency of unnecessary referral duplication.

A dedicated principles and rules function within the Department of Health should be established to support the continued interpretation, implementation and routine revision of specialist referral rules.

Improving information sharing among service providers through real-time health information exchange would avoid the need for low-value administratively driven GP consultations and address any ongoing concerns by GPs regarding the impact of expanded referral pathways and periods of referral validity on continuity and coordination of care. Changes to regulations should be made to mandate timely information flow between all members of a patient's care team. This would reduce the burden on patients, and ensure GPs remain informed irrespective of where the referral originates from.

[74] Prime S 2020, Issues brief: Optimising healthcare through specialist referral reforms, Deeble Institute for Health Policy Research, https://ahha.asn.au/publication/health-policy-issue-briefs/deeble-brief-no-38-optimising-healthcare-through-specialist

TELEHEALTH AND VIRTUAL HEALTHCARE

Key recommendations:

- A research program to explore the practical implementation of virtual care technologies in the Australian setting, including an evaluation of what has worked, what hasn't worked and what can be done better/differently.
- Develop funding models that will support the use of, and equitable access to, virtual care technologies in person-centred models of care.

Opportunity: To implement virtual healthcare technologies effectively and sustainably in long-term health care reform.[75]

Context: As part of the COVID-19 response, the Medicare Benefits Schedule (MBS) was extended to support the wide-scale provision of health care by telehealth, with subsequent amendments to restrict arrangements in general practice to providers who have an existing and continuous relationship with the patient. Private health insurers also agreed to provide benefits for teleconsultations. With Australians more open to using technology in health care, this has led to optimism across the sector that there will be a willingness to embrace these technologies in care to achieve more long-term health care reform.

While many contemporary telehealth initiatives are based on consultations by telephone or videoconference, to achieve system transformation it may be more appropriately defined as: '*the delivery of care from a distance … provided synchronously or asynchronously. The format can be healthcare practitioner to practitioner, patient to healthcare practitioner, or group consultation between patients or practitioners. It can also involve patients and clinicians interacting with wearable or other monitoring devices and decision support algorithms*'.[76]

As telehealth is often understood as referring to teleconsultations, this paper refers to 'virtual health care' in order to better reflect the diversity of technologies and models of care. The SAMR Model from the education sector[77] may be useful to frame the integration of technology in health care. In this model, the use of technology may be introduced to enhance care through substitution or augmentation, or transform care through modification or redefinition (see Figure 1), with different approaches requiring different policy considerations.

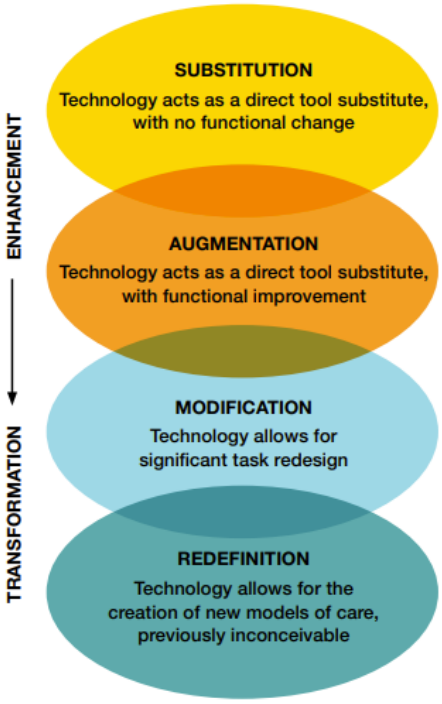


Figure 1. SAMR Model
(image adapted from showbie.com 2014)

[75] AHHA 2020, The effective and sustainable adoption of virtual health care, https://ahha.asn.au/sites/default/files/docs/policy-issue/ahha_blueprint_supplement_-_adoption_of_virtual_health_care_-_july_2020_0.pdf

[76] Snoswell, C, Gray, L, Brooks, P, et al 2019, Developing a policy strategy for telehealth in Australia: a summary of the telehealth FUTURES forum, Online (Centre for Online Health): NHMRC Centre for Research Excellence in Telehealth, The University of Queensland, https://espace.library.uq.edu.au/view/UQ:e39e00e

[77] Puentedura, R 2012, Building upon SAMR, http://hippasus.com/rrpweblog/archives/2012/09/03/BuildingUponSAMR.pdf

Moving from telehealth to virtual health care requires a focus on funding, governance and other policy issues that will support system transformation rather than the more limited system enhancement currently under way.

RESEARCH PROGRAM TO SUPPORT FUTURE INNOVATION

Proposal: Commission six policy evidence briefs that explore the practical implementation of virtual care technologies in the Australian setting, and include an evaluation of what has worked, what hasn't worked and what can be done better/differently.

Through the synthesis of research evidence, these briefs are designed to help decision-makers quickly find out what evidence exists in a topic area, how compelling it is, and what the implications might be when using it to develop health policies.

Building on the Australian Healthcare and Hospitals Association's (AHHA) policy paper on virtual care, which sets out six pre-requisites to move from telehealth as a substitution activity to transformational virtual care, the evidence briefs would draw on the innovation demonstrated during the COVID-19 pandemic or inspired by it. The six selected policy settings are domains which will assist in moving towards greater self-care, a reduced reliance on hospital care, and strengthening capability and capacity in primary care.

1. Patient-centredness	How virtual health care can be more responsive to the needs of the patient, e.g. in 'rapid recovery' pathways following arthroplasty, or to monitor social participation and quality of life in aged care
2. Equity	How equity can be proactively assured in the adoption of virtual models of care, e.g. through supporting at-risk populations who are COVID-positive to isolate at home, or supporting cancer care in rural and regional areas
3. Cross-sector leadership and governance	The opportunities for joint planning and funding of virtual models of care to support the patient's entire care pathway, e.g. expanding use of digital health pathways between health, aged care and disability sectors
4. Digitally-capable workforce providing team-based care	The clinical leadership required and the capabilities developed to leverage the opportunities that technology provides in health care, e.g. as artificial intelligence is adopted in radiology and medical imaging
5. Interoperability and quality assured technology	How care models and clinical processes can integrate with the rapidly evolving availability of digital devices and software, e.g. wearables that support remote monitoring such as smart helmets to monitor for brain seizures or microwearable sensors to monitor vital signs
6. Funding for reform	How funding models influence the effective adoption of virtual care models, e.g. in providing remote monitoring for heart failure or in aged care to support living at home longer

The evidence briefs would be written by AHHA researchers and/or our university partners, with an Expression of Interest process used to identify suitable case studies and authors.

Cost: $300,000 to support research and authoring.

MBS FUNDING

Proposal: In addition to introducing telehealth MBS items across the health care team, develop funding models that will support the use of virtual care technologies in person-centred models of care, such as with remote patient monitoring and 'store and forward'.

Ensure equity in the wide-scale implementation of virtual healthcare through research into digital literacy and access, developing strategies that support engagement with and equitable access to virtual healthcare models.

CONCLUSION

This submission outlines a number of areas of reform to the healthcare system that are achievable with appropriate funding and leadership by the Australian Government, working in cooperation with state and territory governments, Primary Health Networks and other groups. This is further supported by the extensive recommendations for health system reform made by AHHA in our *Health people, healthy systems* proposal which outlines changes required to more effectively deliver healthcare services, improve patient care and achieve system efficiencies. The 2021 edition of the Blueprint is available at www.ahha.asn.au/Blueprint and addresses four domains for health system reform: governance, data, funding and workforce.

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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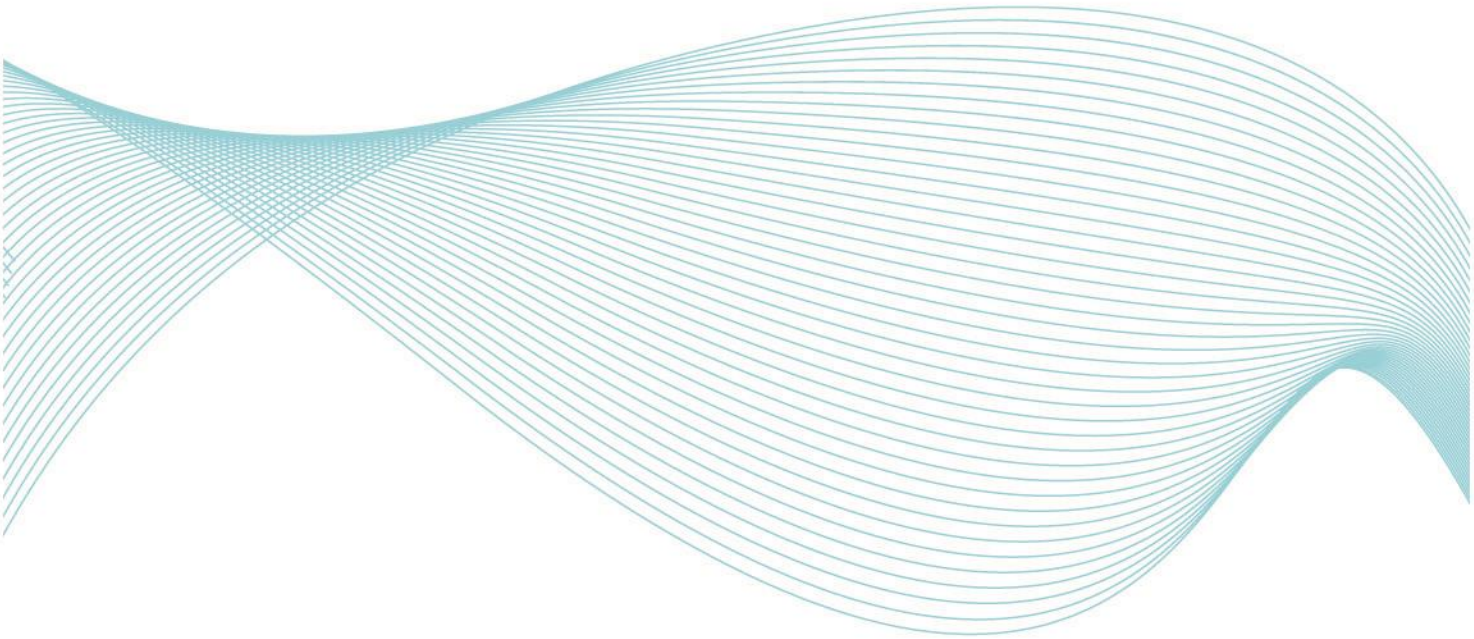

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