2018–19 Pre-Budget Submission to Treasury

December 2017

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Introduction

The Australian Healthcare and Hospitals Association (AHHA) welcomes this opportunity to provide a submission in advance of the 2018–19 Australian Government Budget.

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

Ongoing renewal and reform are features of the Australian health system, driven both by budget pressures and a desire for system improvement. Australians place high value on universal access to a quality health system. To meet this expectation, the 2018–19 Budget must ensure its health policies and reforms will continue to support an effective, accessible, equitable and sustainable healthcare system focused on quality outcomes.

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

Health policy should not be determined by economic policy, but rather what is in the best interests of meeting the healthcare needs of all Australians in an economically sustainable manner. The Australian Government recognised the importance the Australian public place on universal healthcare with their initiatives announced in the 2016–17 Budget to Guarantee Medicare. The recommendations made in this submission provide the opportunity to build on this expressed commitment to develop a more sustainable, coordinated, accessible and fair healthcare system.

Summary of Recommendations

Policy Area	Government Action Required
Funding for value and outcomes in healthcare	- A nationally unified and regionally controlled healthcare system that puts patients at the centre is established. - Infrastructure is developed to have performance information and reporting on the healthcare system that is fit for purpose. - A national healthcare workforce reform strategy is developed focusing on changes in scopes of practice and coordination of education, regulation and funding. - Funding is sustainable and appropriate to support a high quality healthcare system.
Public hospital funding from 1 July 2020	- The agreement between the Commonwealth, state and territory governments on funding of public hospitals from 1 July 2020 continues to be based on activity based funding, with the Independent Hospital Pricing Authority continuing to determine the Nationally Efficient Price and Cost as a fully independent and appropriately funded body. - An independent national health authority is established to develop strategies to improve integration of healthcare services, remove waste and duplication within and across sectors, and to identify low value healthcare.
Coordinated healthcare	- Patient care is coordinated both within the healthcare system and through interactions with the aged and disability care sectors. - Models of coordinated care are responsive to local need and local capacity with flexibility to respond according to the broader objective of better patient care. - Primary Health Networks have a key role in leading this work in partnership with Local Hospital Networks (or equivalent) and local service providers.
Oral health	- Commonwealth funding for the National Partnership Agreement for public dental services to adults is restored to $155 million per year. - The Child Dental Benefit Schedule is promoted effectively. - A performance and reporting structure focused on outcomes rather than throughput is developed. - Funding allocations reflect the cost of providing care in rural and remote areas, smaller jurisdictions and to groups with high needs. - An Australian Chief Dental Officer is appointed to provide national coordination of oral health policy. - The fluoridation of all reticulated water supplies in Australia is supported. - An increase in the number of dental practitioners in remote and regional communities is supported.

Policy Area	Government Action Required

Private health insurance	- A comprehensive Productivity Commission inquiry is established looking at the costs and benefits of private health insurance within the overall health sector.
	- Various recommendations on different aspects of private health insurance as they relate to PrivateHealth.gov.au and private health insurance policy design relating to:
	  - Aboriginal and Torres Strait Islander peoples;
	  - Ambulance services;
	  - Non admitted hospital procedures;
	  - Primary healthcare;
	  - People in rural and remote areas;
	  - Communicating policy changes;
	  - Private Health Insurance Rebate;
	  - The provision of private health insurance data;
	  - Price transparency and informed decision making;
	  - Acceptable levels of insurer profitability and premium increases; and
	  - Preferred providers.

Health workforce	- A national workforce reform strategy is developed that goes beyond the adequacy, quality and distribution of the health workforce as it currently exists. The strategy will provide direction on outcomes-focused and value-based changes in scopes of practice and models of care to meet public need, with coordination of education, regulation and funding (at the Commonwealth, state and territory and regional service levels), for both regulated and unregistered health professions.
Preventive healthcare	- The Commonwealth Government prioritises development and implementation of preventive health strategies. These strategies will direct attention to common risk factors and determinants including overweight and obesity, alcohol misuse and abuse, tobacco consumption, inequality and immunisation. - Funding for preventive health targets a return to funding levels commensurate with the average in recent years of around 2.3% of recurrent expenditure on health. - A cooperative approach between Primary Health Networks and Local Hospital Networks is established to develop shared regional needs assessments, priority setting and funding for regionally targeted preventive health initiatives that respond to local community needs. - There is investment in evidenced-based strategies to discourage the consumption of sugar-sweetened beverages. This will include measures to regulate availability, improve labelling, restrict promotion, reduce consumption, increase public awareness and implement a 20% ad valorem sugar-sweetened beverages tax. Revenue raised from a sugar sweetened beverages tax should be hypothecated for preventive health measures.

Policy Area	Government Action Required
Advance care planning and palliative care	- A nationally consistent legislative framework is developed to support end-of-life decision-making and advance care planning. - Integration of advance care planning documents in My Health Record with primary care, hospital, community and aged care electronic health records is enhanced. - 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, 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 palliative care is developed. - Advance care planning and palliative care are included in the aged care accreditation and quality framework.
Urgent after hours care	- The Medicare Benefits Schedule Review Taskforce recommendations relating to urgent after hours primary healthcare services are not accepted. - Concerns relating to the inappropriate use of urgent after hours MBS items are more rigorously and impartially investigated, with a focus on patient need and broader health system implications of proposed policy changes.
Close the Gap	- The matrix for identifying, measuring and monitoring institutional racism for hospitals and health services across Australia is validated. $0.5M. - Targeted long term programs to increase Aboriginal and Torres Strait Islander representation in the health workforce are delivered. - The Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013-2014 is funded.
Closing the Gap prescriptions	- The Closing the Gap PBS Measures are reviewed to enable provision of key medicines to Aboriginal and Torres Strait Islander patients regardless of setting.

1 Funding for value and outcomes in healthcare

Key Recommendations:
- A nationally unified and regionally controlled healthcare system that puts patients at the centre is established.
- Infrastructure is developed to have performance information and reporting on the healthcare system that is fit for purpose.
- A national healthcare workforce reform strategy is developed focusing on changes in scopes of practice and coordination of education, regulation and funding.
- Funding is sustainable and appropriate to support a high quality healthcare system.

Over the next ten years, Australia must reorientate the healthcare system to meet contemporary needs and emerging challenges. Maintaining the status quo and tinkering around the edges of system reform will not provide the future-proofed health system that Australians expect and deserve.

The current fee for service funding model in Australia places the focus on throughput of patients rather than sustained, improved health outcomes being achieved. An essential element to reform models of care is to have an agreed set of health outcome indicators and the necessary data collection infrastructure to support assessment against this framework. This would then enable funding models that are based on achieving value and outcomes in healthcare to be implemented.

The AHHA supports a performance and reporting structure focusing on outcomes, rather than throughput, through the development of indicators, which could then be tied to outcomes based funding when more timely and robust data collection and dissemination is in place to enable such a change. This performance and reporting structure should also be consistent across services (e.g. general practice, pharmacy, allied health, community health services etc.) to enable comparisons to be made of innovations in scopes of practice and role substitution. Any form of payment for performance must ensure that it is more than penalties for adverse events and that it incentivises quality improvement. The use of proxy indicators and data that are not fit for purpose do not adequately meet this objective.

Outcomes-focused and value-based healthcare requires a whole-of-government approach to achieve:

1. **A nationally unified and regionally controlled health system that puts patients at the centre.** Leadership is needed to ensure the mechanisms to effect change at the regional level, and at appropriate scale and pace, are established. For regional accountability and responsiveness, governance arrangements across the health sector need to ensure desired outcomes and value can be achieved. This will promote coordination of health service delivery, address unmet need and improve efficiency. This can be achieved by:
   - Within 2 years: the establishment of an independent national health authority with a skills-based multi-jurisdictional board consisting of patient and professional expertise which is distinct from Commonwealth, state and territory health departments and reports directly to the Council of Australian Governments (COAG) or the COAG Health Council;
   - Within 2 years: establishment of formal Primary Health Network and Local Hospital Network governance arrangements to ensure joint needs assessments, priority setting, and funding for coordinated and integrated care; and
   - Within 5 years: the independent authority's reporting replaces current reporting (e.g. the Australian Institute for Health and Welfare and the Report on Government Services) and supports alignment of national agreements (e.g. the Community Pharmacy Agreement and the national mental health agreement).

2. **Performance information and reporting that is fit for purpose.**
   Leadership is needed to establish a system where data accurately reflect care outcomes and are in the right format, timely and of sufficient quality to discern critical relationships between investment and results, produced as appropriate for different audiences and purposes. This can be achieved by:
   - Within 2 years: providers and other organisations that receive government funds being required to supply patient outcomes data;
   - Within 2 years: establishment of a primary healthcare national minimum data set with agreed definitions and linked to current and future government funding instruments;
   - Within 2 years: development of a national framework for value-based patient-centred outcomes focused on data collection, use and reporting;
   - Within 2 years: the Australian Digital Health Agency fast-tracking the development of interoperability standards to support better information sharing across the health system;
   - Within 2 years: work currently underway considering secondary use of My Health Record data includes using outcomes data to support better stewardship and governance of the health sector;
   - Within 5 years: standards for general practice electronic health records being developed and implemented to support interoperability; and
   - Within 7–10 years: outcomes data being publicly published to empower patients to make informed choices about treatment options and providers, including data on the outcomes that are most important to individual patients.

3. **A health workforce that exists to serve and meet population health needs.**
   Leadership is needed to proactively redefine traditional workforce models of healthcare delivery that better address population health needs. Leaders must recognise that vested professional and financial incentives are an impediment to effective structural reforms in the way health services are designed, delivered and remunerated. This can be achieved with:
   - A national health workforce reform strategy being developed, including action plans for medium term (within 5 years) and longer term (within 7–10 years) reforms. The strategy needs to go beyond adequacy, quality and distribution of the workforce as it currently exists and requires a focus on changes in scopes of practice and coordination of education, regulation and funding.

4. **Funding that is sustainable and appropriate to support a high quality health system.**
   Leadership is needed to ensure funding is directed to health sector priorities and used effectively and efficiently to deliver high-value services. While payment mechanisms are just one of the policy levers to address quality in healthcare, they are recognised as a powerful instrument in altering health provider behaviour in terms of the volume and quality of health services delivered. This can be achieved by:
   - Within 2 years: current Commonwealth funding levels for public hospitals, including the growth formula, being maintained for 7 years with a review commencing at year 5, to determine funding which could be quarantined as pooled Primary Health Network and Local Health Network regional funding for cross-sector care coordination and delivery;
   - Within 2 years: funding of commissioned services occurring at a regional level through pooled funding between Primary Health Networks and Local Health Networks;
   - Within 2 years: trialling a mixed funding formula (including activity-, block- and performance-related funding measures) for the management of four of the top chronic diseases, risk factors or determinants, with a 25% component for achieved health outcomes and/or inclusive of top 3–5 avoidable hospital readmission indicators;
   - Within 5 years: preventive activities funded based on regional population needs; and
   - Within 7–10 years: stakeholders being given financial incentives to improve healthcare value on the basis of outcomes data.

2 Public hospital funding from 1 July 2020

Key Recommendations:
- The agreement between the Commonwealth, state and territory governments on funding of public hospitals from 1 July 2020 continues to be based on activity based funding, with the Independent Hospital Pricing Authority continuing to determine the Nationally Efficient Price and Cost as a fully independent and appropriately funded body.
- An independent national health authority is established to develop strategies to improve integration of healthcare services, remove waste and duplication within and across sectors, and to identify low value healthcare.

The Commonwealth agreed with all state and territory governments through a Council of Australian Governments (COAG) Heads of Agreement on 1 April 2016 to develop a longer term public hospital funding agreement to take effect from 2020–21 and which is to be considered by COAG before September 2018. The COAG Communique of 9 June 2017 confirmed that longer-term hospitals funding arrangements will be agreed in 2018.

In negotiating this funding agreement between the Commonwealth, state and territory governments to apply from 1 July 2020, AHHA calls on the Australian Government to ensure the following principles are adhered to:
- Public hospital funding will continue to be provided on the basis of activity based funding, with block funding for smaller public hospitals as appropriate;
- The Independent Hospital Pricing Authority retains its role in determining the National Efficient Price (and associated weighted activity units) and the National Efficient Cost as a fully independent and appropriately funded body;
- Any funding caps applied by the Commonwealth in the new funding agreement for public hospitals from 2020–21 should not impose limits in the growth in Commonwealth funding beyond the 6.5% applied in the current interim public hospital funding arrangements; and
  Any form of payment for performance must ensure that it is more than penalties for adverse events and that it incentivises quality improvement.

Consistent with the Commonwealth reforms to primary healthcare identified in the 1 April 2016 Heads of Agreement, the Commonwealth should also establish an independent national health authority with responsibility to improve integration of healthcare services, remove waste and duplication within and across sectors, and to identify low value healthcare. This would lead to both system efficiencies and better patient care. Upon establishment, this independent body should assume functions currently let by the Independent Hospital Pricing Authority, the Administrator of the National Health Funding Pool, the Australian Institute of Health and Welfare, the Digital Health Agency and the Australian Commission on Safety and Quality in Healthcare. This independent body should also be tasked with ensuring recommendations from the various reviews of the health sector currently being conducted are implemented in a coordinated manner that do not create adverse impacts on other parts of the health system.

3 Coordinated care

Key Recommendations:
- Patient care is coordinated both within the healthcare system and through interactions with the aged and disability care sectors.
- Models of coordinated care are responsive to local need and local capacity with flexibility to respond according to the broader objective of better patient care.
- Primary Health Networks have a key role in leading this work in partnership with Local Hospital Networks (or equivalent) and local service providers.

The presence of fragmented and uncoordinated healthcare within Australia is well known, leading to sub-optimal patient care and system inefficiencies. The need for coordinated care addresses the current silo approach to care giving – both within the healthcare system and through interactions with the aged and disability care sectors. The policy direction should be to reduce fragmentation and improve coordination of patient treatments through their care journey. This includes:
- A commitment to taking proactive responsibility for coordination of care;
- Developing an interconnectedness across all settings and services, including coordinating with family members, community organisations, oral health, mental health and other clinicians and professionals; and
- Helping patients manage all the recommendations they receive from other clinicians and professionals, including reconciling differences when recommendations conflict or contradict, and closing the loop between the patient and their care providers.

There is recent recognition of the importance of coordinated healthcare reflected in the 1 April 2016 COAG Heads of Agreement between the Commonwealth, state and territory governments with specific steps outlined to improve coordination between primary healthcare and hospital care. The pending changes to funding for public hospital treatments associated with avoidable readmissions also highlight the need for better coordination of a patient's healthcare as they transition across different points of the healthcare system. The continued upload and use of My Health Record also has an important role because it enables, "better coordination and quality of healthcare" (DoH 2016, page 6).

There should be a nationally unified and regionally controlled health system that puts patients at the centre. Models of coordinated care must be responsive to local need and local capacity with flexibility to respond according to the broader objective of better patient care. Primary Health Networks should have a key role in leading this work, guided by their Clinical Councils and Community Advisory Committees, in partnership with general practices, Aboriginal Community Controlled Health Services, allied health providers and hospital networks.

While well-delivered coordinated care can involve larger upfront costs, the associated significant gains from the mitigation and better management of chronic disease may only be realised over the longer term. Balanced against this, the CSIRO report on the Home Monitoring of Chronic Disease for Aged Care trial found that large savings were realised from reduced hospital admissions and reduced length of stay (Cellar *et al* 2016).

Proactive leadership to reform the healthcare system can achieve both better patient outcomes and improved system efficiencies. Governments need to work in partnership to achieve this goal. Vested professional and financial interests should not be permitted to stifle innovation within the health sector.

4 Oral health

Key Recommendations:
- Commonwealth funding for the National Partnership Agreement for public dental services to adults is restored to $155 million per year.
- The Child Dental Benefit Schedule is promoted effectively.
- A performance and reporting structure focused on outcomes rather than throughput is developed.
- Funding allocations reflect the cost of providing care in rural and remote areas, smaller jurisdictions and to groups with high needs.
- An Australian Chief Dental Officer is appointed to provide national coordination of oral health policy.
- The fluoridation of all reticulated water supplies in Australia is supported.
- An increase in the number of dental practitioners in remote and regional communities is supported.

Public dental treatment

The 2014–15 Budget cut $650 million from dental programs across the forward estimates, in addition to expenditure cuts of $42.4 million made in the 2013–14 MYEFO (Russell 2014). In the 2015–16 Budget, further measures relating to dental health were introduced with a reduction in expenditure of $125.6 million across the forward estimates from the CDBS, in addition to reduced expenditure on dental workforce programs and payments to Department of Veterans' Affairs dental health providers. This Budget also removed funding in the forward estimates for adult public dental services (CoA 2015). On 15 December 2016, the then Minister for Health and Aged Care announced funding cuts for public dental services as of 1 January 2017 (Ley 2016).

While the Minister announced the National Partnership Agreement for public dental services to adults will continue to receive Federal funding of $320 million in 2017–19 (or less than $107 million per year for the next three years), this is a reduction from the former Minister's announcement of about $155 million in calendar year 2016. The original Budget measure in 2013–14 allocated $391 million in 2016–17. This will result in as many as 338,000 Australians losing access to timely and affordable care. The Government's decision to reduce federal funding to the states and territories for the provision of essential dental services to the most vulnerable in the community means that wait times at public dental clinics, which are already running into years, will only get longer and leave more patients at risk. These changes will negatively impact Australians least able to afford proper dental care.

AHHA recommends the restoration of Commonwealth interim funding for the National Partnership Agreement for public dental services to adults at $155 million per year—in line with calendar year 2016 funding levels—until a new National Partnership Agreement (or agreements) are settled by Commonwealth, state and territory governments. AHHA supports 'maintenance of effort' requirements for the agreement(s) to maintain current levels of state and territory investment in oral health when additional Commonwealth funding, including Child Dental Benefits Schedule (CDBS) funds, are provided.

Disease impact

Tooth decay is the most common health problem in Australia, nine out of ten Australians have had some decay in their teeth (NHMRC 2017). Around three in ten Australian adults have untreated tooth decay (AHMAC 2015). The social determinants of health have a profound impact on tooth decay, periodontal disease and tooth loss (Chrisopoulos, Harford and Ellershaw 2016; Ha 2011).

Good oral health is fundamental to health, wellbeing and quality of life. A healthy mouth enables people to eat, speak and socialise without pain, discomfort or embarrassment. Oral health problems affect general health. As a common risk factor for chronic diseases, oral disease is significantly associated with cardiovascular disease, diabetes, stroke and respiratory disease. Poor oral health can also impact on birth outcomes, including preterm-births and low birth weight (National Advisory Council on Dental Health 2012).

AHHA calls for the appointment of an Australian Chief Dental Officer to provide national coordination of oral health policy development and implementation of the National Oral Health Plan. This should be funded from 2018–19. The estimated cost of such an appointment is $0.5 million per annum.

AHHA supports a performance and reporting structure focusing on outcomes, rather than throughput, through the development of oral health indicators. This should then be tied to outcomes based funding when more timely and robust data collection and dissemination is in place to enable such a change. Investment in this data and indicator development work should be prioritised in 2018–19. The estimated cost of developing this framework is $1.0 million.

Prevention

There is consistent evidence that water fluoridation at current Australian levels is associated with decreased occurrence and severity of tooth decay in children, adolescents and adults. (NHMRC 2017). Nearly 3 million Australians, more than 11% of the Australian population, do not have a fluoridated water supply (ABS 2017; NHMRC 2017).

The Commonwealth should provide national leadership by working with state and territory government to ensure fluoridation of all reticulated water supplies in Australia. AHHA supports a linkage between Commonwealth funding and the extent of state and territory water fluoridation programs, although recognising that funding allocations must also reflect the full cost of providing care in rural and remote areas, smaller jurisdictions and to groups with high needs.

Barriers to treatment

Out-of-pocket cost to individuals is acknowledged as the major barrier. In Australia payment for dental treatment is primarily borne by individuals with 58.2% of national dental expenditure. Health funds paid 16.0%, the Commonwealth's direct outlay was 10.8% with an additional 7% from health insurance premium rebates and 7.5% from state and territory governments (AHMAC 2015).

The out-of-pocket cost barrier has a differential effect upon whether people attend a dentist, have the treatment they need and feel the financial burden of dental treatment costs. More than 30% report that they avoid or delay visiting a dentist due to cost (Chrisopoulos, Harford and Ellershaw 2016). Those in lower household income groups had higher rates of avoiding or delaying a visit to a dentist due to cost than those in higher income groups.

Access to dental practitioners is also a barrier to dental care, particularly for those Australians living in rural and remote Australia. Capital cities have nearly 2.5 times more dental practitioners per person than remote areas (NHWDS 2017). In small towns this widened, despite improved national averages, since 1981 (Bourne, Nash and Houghton 2017).

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

5 Private health insurance

Key Recommendations:

- A comprehensive Productivity Commission inquiry is established looking at the costs and benefits of private health insurance within the overall health sector.
- Actions targeting different aspects of private health insurance as they relate to PrivateHealth.gov.au and private health insurance policy design are taken relating to:
  - Aboriginal and Torres Strait Islander peoples;
  - Ambulance services;
  - Non-admitted hospital procedures;
  - Primary healthcare;
  - People in rural and remote areas;
  - Communicating policy changes;
  - Private Health Insurance Rebate;
  - The provision of private health insurance data;
  - Price transparency and informed decision making;
  - Acceptable levels of insurer profitability and premium increases; and
  - Preferred providers.

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

With more than $6.4 billion of public money to be given to private health insurers through the Private Health Insurance Rebate in 2017–18, and only one-half of all Australians using PHI, the Commonwealth Government should establish a comprehensive Productivity Commission inquiry looking at the costs and benefits of PHI within the overall health sector. The Productivity Commission inquiry should also consider appropriate levels of profitability within the PHI sector, which has become increasingly for-profit driven, but is heavily subsidised and has government policy pushing the public into taking out health insurance policies.

Foundational principles of Australia's universal healthcare system include that clinicians are free to provide their services as private providers; and that patient choice is available, both for services from clinicians and from hospitals.

In many parts of regional, rural and remote Australia, there are no private hospitals available—and for patients to exercise choice regarding clinicians, the opportunity to use PHI in public hospitals must be preserved. Recruitment and retention of health workforce in regional, rural and remote areas is also underpinned by the opportunity for providers to be able to offer private services in public hospitals.

In the children's hospital sector there are few, if any, private hospital options.

State and territory health departments have protocols and guidelines regarding communications with patients about the use of PHI, and associated complaints mechanisms. A more fulsome analysis of public hospital service utilisation by private patients would examine how these protocols are implemented in hospitals, and any related complaints data.

To address these concerns, it is vital that the Commonwealth proactively engage with the sector based upon its health system stewardship role.

AHHA recommendations

Productivity Commission review

- The Commonwealth Government should establish a comprehensive Productivity Commission inquiry looking at the costs and benefits of PHI within the overall health sector
- Should the inquiry recommend the abolition of the Private Health Insurance Rebate in its entirety, these savings should be transparently re-directed to the public health system. However, should the rebate be retained, its application should be limited to products which meet the simplified gold, silver and bronze product specifications.
- Any application of the rebate to general treatment cover should only apply to policies covering safe and effective evidence-based treatments known to maintain and improve the health of consumers.
- Should the Government decide to remove the Private Health Insurance Rebate for all general treatment cover, the AHHA contends that the MBS should be broadened to support access to evidence-based primary and sub-acute health services such as dental, physiotherapy and psychology services, for example, as part of bundled health packages currently under consideration in the review of primary healthcare.

PrivateHealth.gov.au

- The Commonwealth Government should invest in promoting PrivateHealth.gov.au nationally and on an on-going basis.
- PHI providers should be required to prominently promote PrivateHealth.gov.au across their media platforms and as part of their advertising campaigns as a condition of receiving government support and funding.

Private health insurance policy design—Aboriginal and Torres Strait Islander peoples

- PHI providers should be encouraged to work together with Aboriginal and Torres Strait Islanders health organisations and consumer representatives to develop more culturally appropriate products.
- It is an oversight that Aboriginal and Torres Strait Islander representation is not included in the membership of the Commonwealth's Private Health Ministerial Advisory Committee, and Aboriginal and Torres Strait Islander representation should be included in current and future Commonwealth advisory work on PHI.

Private health insurance policy design—ambulance

- The Commonwealth Government should consider removing ambulance insurance from PHI policies and replacing it instead with a universal scheme for ambulance coverage. This could be funded as part of the redirection of funds from the Private Health Insurance Rebate towards the public healthcare system. The Commonwealth Government would need to closely monitor insurers to ensure that the savings from not offering ambulance cover are passed on as reduced premiums.

Private health insurance policy design—non-admitted hospital procedures

- Where medical services are provided on referral from the hospital in an outpatient, community or home setting, these services should be eligible for cover through PHI.

Private health insurance policy design—primary healthcare

- The Commonwealth Government should clearly define its expectations of the role of private health insurers in primary healthcare, and any increased role for private health insurers in primary healthcare must neither reduce access nor increase costs for non-insured consumers.

Private health insurance policy design—rural and remote

- Because rural and remote PHI policy holders do not receive similar value as metropolitan policy holders, and because Commonwealth incentives attempt to increase the number of PHI policy holders and the use of private hospital services, PHI providers should be mandated to offer rural and remote policy holders transportation and accommodation support to undergo private procedures in metropolitan centres.
- To ensure equity of costs incurred across health insurance providers, a risk equalisation pool should be developed such that the risk-adjusted costs associated with such a scheme are equitably shared across insurers.

Communicating private health insurance policy changes

- The Commonwealth Government should mandate a method of communicating policy changes to consumers which should guarantee timely communication and allow consumers adequate time to change product or provider without being penalised or inconvenienced.

Community rating and risk equalisation

- The Commonwealth Government should retain community rating as set out in the Private Health Insurance Act 2007 in tandem with risk equalisation, and that risk stratified policies should not be permitted to be offered by private health insurers.

Data

- Better data is required to understand the use of PHI in public hospitals. This data should be disaggregated to hospital level and should identify the case-mix of patients using the public system and PHI in public and private hospitals. More nuanced data on exclusionary products is needed. More detail is also needed on the number of complaints received at the jurisdictional level on the use of PHI in public hospitals.

Price transparency and informed decision making

- In order to increase price transparency and informed decision making, specialist and general practitioner fees should be published by procedure name indicating at a minimum the top and bottom decile, median fee and the Medicare fee, and reported by Primary Health Network region in a timely and regular manner.

Private health insurance industry—profitability

- The Commonwealth Government should initiate an inquiry into appropriate levels of profitability and returns to equity within the PHI industry, taking explicit account of Government policies that remove significant levels of uncertainty concerning industry revenues being received. The findings from this inquiry must then be used when evaluating the appropriateness of any requests from PHI providers to increase premiums on their products.

Private health insurance industry—preferred providers

- PHI providers should not be permitted to establish networks of preferred health service providers offering discounted service provision nor to establish their own facilities for a range of health services and treatments if they retain eligibility for the PHI Rebate.

6 Health workforce

Key Recommendation:
- A national workforce reform strategy is developed that goes beyond the adequacy, quality and distribution of the health workforce as it currently exists. The strategy will provide direction on outcomes-focused and value-based changes in scopes of practice and models of care to meet public need, with coordination of education, regulation and funding (at the Commonwealth, state and territory and regional service levels), for both regulated and unregistered health professions.

There are joint roles and responsibilities between Commonwealth Government, and the state and territory governments relating to the health workforce and their education and training requirements (COAG 2012; COAG 2017).

At both Commonwealth, and state and territory levels, there is significant focus on the number and distribution of health professionals regulated under the Health Practitioner Regulation National Law Act 2009 (the National Law), in particular medical professionals and nurses. However, data does not currently capture information about accessibility, responsiveness, acceptability, quality and appropriateness. Further, data on numbers and distribution need to be interpreted in terms of evolving and innovative changes in scopes of practice and models of care, particularly with growing evidence of comparative cost-effectiveness of allied health led-care and multidisciplinary involvement in models of care across the patient journey (Office for Professional Leadership 2015). Relationships with scopes of practice and use of the non-registered workforce are also unknown.

The Productivity Commission noted 'Labour costs comprise a large share of health expenditure, and so making better use of health workforce skills and competencies could lead to large efficiency gains. There is evidence that some tasks that are currently the exclusive responsibility of particular professionals could be performed just as effectively by others, without compromising patient safety or the quality of care' (PC 2015).

The former Health Workforce Australia reported that a 'business as usual' approach to the health workforce is not sustainable, with a need for coordinated, long-term reforms by government, professions and the higher education and training sector for a sustainable and affordable health workforce. The main policy levers required for change were innovation and reform, immigration, training capacity and efficiency and workforce distribution, with innovation and reform measures identified as the area of most promise (HWA 2013).

While the National Law has an objective 'to enable the continuous development of a flexible, responsive and sustainable Australian health workforce' (Health Practitioner National Law Act 2009), there is no shared vision documented for what such a workforce looks like. Further, there are limited mechanisms to ensure a match between health professional education and training which is controlled nationally, and the workforce needs of the largely state-controlled healthcare organisations (Leggat 2014). In the review of the National Registration and Accreditation Scheme (NRAS), it was identified that an improved mutual understanding about the future agenda in workforce reform was needed. Submissions to the review showed an almost universal agreement on the importance of developing national workforce policy guidance that can be acted upon by all entities and processes within, and interdependent with, NRAS–consumers, employers, professional associations, education providers, National Boards and government departments (Woods 2017).

Within this context, clinical training and experience, particularly for clinical placements, is recognised as a critical component in preparing health professionals for practice. The quality of and time in pre-registration placements has been recognised as one of the main influencing factors in determining career destinations for health professionals (Universities Australia 2017). Support and incentives for placements are critical in terms of rural and remote distribution, but should also be considered in terms of areas of public need and service models. With drivers to shift care from hospital to primary and community care sectors, there need to be similar drivers supporting clinical training and placements in these settings, including primary healthcare, disability care, aged care and mental health. Without sufficient exposure to healthcare settings outside of public hospitals, the choice to practice in other settings (and readiness to do so) is reduced. Promoting efficient and sustainable use of limited clinical training resources is of value and benefit to all stakeholders. While the Independent Hospital and Pricing Authority (IHPA) is designing a nationally consistent method of classifying teaching and training activities and the associated costs to inform activity based funding (ABF) in public hospitals, consideration of, and responsibility for, placements beyond the hospital environment needs attention.

7 Preventive healthcare

Key Recommendations:

- The Commonwealth Government prioritises development and implementation of preventive health strategies. These strategies will direct attention to common risk factors and determinants including overweight and obesity, alcohol misuse and abuse, tobacco consumption, inequality and immunisation.
- Funding for preventive health targets a return to funding levels commensurate with the average in recent years of around 2.3% of recurrent expenditure on health.
- A cooperative approach between Primary Health Networks and Local Hospital Networks is established to develop shared regional needs assessments, priority setting and funding for regionally targeted preventive health initiatives that respond to local community needs.
- There is investment in evidenced-based strategies to discourage the consumption of sugar-sweetened beverages. This will include measures to regulate availability, improve labelling, restrict promotion, reduce consumption, increase public awareness and implement a 20% ad valorem sugar-sweetened beverages tax. Revenue raised from a sugar-sweetened beverages tax should be hypothecated for preventive health measures.

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 the social determinants of health, as well as a preventive approach to healthcare, supported by deliberate investment by government.

Health should be seen as an investment, not just a cost. As reinforced in the recent report of the Productivity Commission, there is a strong rationale for a greater emphasis on public health and prevention in an integrated system (PC 2017), 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.

Preventive health measures aim to reduce illness, prevent disease and promote wellness. This in turn reduces individual, intergenerational and health system burden, improves health system resource use and boosts productivity through greater economic participation and productivity. Yet Australia spends less on public health and prevention than most other OECD countries, ranked fourth lowest in 2014, with 1.9% of recurrent health spending compared with Canada's 6.3% and the United Kingdom's 5.1% (OECD 2017). Since peaking at 2.3% in 2007–08, Australian spending has fallen to 1.7% in 2015–16 (AIHW 2017).

Chronic disease is responsible for 83% of all premature deaths in Australia and 66% of the burden of disease (GBD 2015). Despite this, 31% of Australia's burden of disease is preventable (AIHW 2016), intensifying the need for investment in evidence-based, cost-effective preventive health strategies.

While investing in preventive health measures generates a short term cost, such initiatives can also create savings in reduced healthcare costs in the future and improve quality of life over the life course. With the fourth Intergenerational Report highlighting the pressure that health costs will place on the Commonwealth Budget (Treasury 2015), it is vital that there be a significant investment in preventive health strategies to lessen the individual, intergenerational and health system burden which will otherwise emerge in the future. This is also consistent with Objective 1 of The National Strategic Framework for Chronic Conditions, which is 'to focus on prevention for a healthier Australia' (AHMAC 2017).

Funding for preventive health should target a return to funding levels commensurate with the average in recent years of around 2.3% of recurrent expenditure on health on activities including health promotion, prevention and early intervention.

Funds dedicated to prevention activities must be based on regional need. A collaborative approach is required between the Commonwealth, state and territory governments to establish consistent governance arrangements between Primary Health Networks and Local Hospital Networks 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.

A strategic approach to delivering preventive health activities focussed on common risk factors and determinants, rather than individual diseases is also required. This approach must incorporate evaluation and prioritisation of cost-effectiveness, and must also monitor and evaluate performance and outcomes.

Strategic priority areas in preventive health should include:
- Overweight and obesity;
- Alcohol misuse and abuse;
- Tobacco control;
- Inequality; and
- Immunisation.

Obesity is an Australian health priority with 63% of the adult population overweight or obese and obesity surpassing smoking as the leading cause of preventable death or illness and (AIHW 2016). Obesity has high economic and human consequences at an individual and societal level. Australian modelling shows that the direct health costs of obesity in 2011–12 were $3.8 billion (PwC 2015).

Increased consumption of energy-dense nutrient-poor foods is the predominant cause of obesity, with estimates that sugar-sweetened beverages (SSBs) account for at least one fifth of weight gain (Woodward-Lopez et al. 2011). Investment is needed in a broad array of evidenced-based strategies to discourage the consumption of SSBs, incrementally reduce overweight and obesity, and improve health outcomes. This approach should include measures to regulate availability, improve labelling, restrict promotion, reduce consumption and increase public awareness of potential harms.

While this is likely to have a modest impact on population rates of obesity it will result in substantial benefits to population health. An additional 20% ad valorem tax will reduce rates of type 2 diabetes, heart disease and stroke, with an estimated 1,600 extra people alive after 25 years as a result of the tax, providing considerable health system savings and generating an estimated $400 million in revenue annually (Veerman et al. 2016).

Revenue raised from a SSBs tax should be hypothecated for preventive health measures including approaches to improve diet, increase physical activity, prevent obesity and educate on nutrition.

8 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.
- Integration of advance care planning documents in My Health Record with primary care, hospital, community and aged care electronic health records is enhanced.
- 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, 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 palliative care is developed.
- Advance care planning and palliative care are included in the aged care accreditation and quality framework.

Australians are living longer, with the number of deaths in Australia set to double over the next 25 years (Swerissen and Duckett 2014). Palliative care should relieve suffering, preserve dignity, be accessible and enable people to die in a place of their choice. The health system in Australia today provides increasingly aggressive therapies for the frail elderly that often extend life but also have the potential to cause harm. As a nation we have been slow to adapt to the care requirements of the increasing prevalence of chronic diseases and an aging population. Palliative care services have inadequate capacity to provide consistent and coordinated care for current or future needs.

AHHA recognises that balancing healthcare expectations with 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 (McCarthy et al. 2015).

AHHA supports the Senate Community Affairs Reference Committee recommendation to harmonise laws across all jurisdictions about advance care planning documents and substitute decision-makers (CARC 2012). This will support a nationally consistent approach that will protect clinicians from medico-legal risk and provide a decision making framework to support patients in accessing the care that 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 necessary. This should include establishment of items to support involvement of general practitioners, 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 (PC 2016). 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 palliative care to support increased access to high quality regionally appropriate care.

New aged care accreditation and quality standards for residential aged care, home care and flexible care under development must include advance care planning and palliative care. These standards will support access to care, quality of care and outcomes for consumers accessing aged care services.

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.

9 Urgent after hours care

Key Recommendations:
- The Medicare Benefits Schedule Review Taskforce recommendations relating to urgent after-hours primary healthcare services are not accepted.
- Concerns relating to the inappropriate use of urgent after-hours MBS items are more rigorously and impartially investigated, with a focus on patient need and the broader health system implications of proposed policy changes.

The Medicare Benefits Schedule (MBS) Review Taskforce has made a set of recommendations relating to urgent after-hours primary healthcare services funded through the MBS (MBSRT 2017). The recommendations have the effect of constraining to a limited group which suitably qualified medical practitioners can claim for urgent after-hours primary healthcare.

AHHA contends that the Taskforce recommendations, if implemented, would have significant implications for the availability of both urgent and non-urgent after-hours care. This will have a direct adverse impact on patients' access to primary healthcare in the after-hours setting and will result in a spill over of patients seeking alternative care at emergency departments.

The Taskforce report contends that there has been inappropriate use of urgent after-hours MBS items. The appropriate response to this contention should be based on the appropriate use of these MBS items, not constraining which medical practitioners can claim against these items. The issues that must remain prominent is patient access to needed primary healthcare and the broader health system implications of proposed policy changes made in isolation.

The Taskforce report highlights the increased MBS expenditure for items associated with urgent after-hours care and attributes this to inappropriate growth in after-hours primary healthcare provided by medical deputising services. However, the report made no attempt to understand the extent to which this growth was in response to the presence of unmet need in the community due to local general practitioners being unable or unwilling to provide after-hours care.

The Taskforce also provides scant justification for its assessment of the availability of urgent after-hours care on hospital emergency departments. Given the cost of emergency care in a hospital setting and the existing demand pressures on emergency departments, the potential impact of the Taskforce recommendations on access to urgent after-hours care must be more rigorously examined to determine the system level implications of the Taskforce recommendations.

The AHHA does not condone inappropriate billing practices by any medical practitioner. Concerns about the inappropriate use of urgent after-hours MBS items should be addressed by the Commonwealth Government:
- Defining urgent treatment in a manner that is clearly understood by all medical practitioners providing after-hours care and communicated accordingly to patients;
- Ensuring that there is appropriate triage of patients when they contact an after-hours medical service so that the patient is streamed to the appropriate healthcare pathway; and
- Conducting appropriate monitoring and enforcement of the use of urgent after hours MBS items.

The AHHA contends that a more impartial and rigorous assessment of the use of urgent after-hours MBS items needs to be conducted that accounts for the issues raised here. An inquiry on the appropriate use of any MBS items must be focussed on patient need and broader health system implications, not which sub-set of medical practitioners should be permitted to claim against them.

10 Close the Gap

Key Recommendations:
- The matrix for identifying, measuring and monitoring institutional racism for hospitals and health services across Australia is validated. $0.5M
- Targeted long term programs to increase Aboriginal and Torres Strait Islander representation in the health workforce are delivered.
- The Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013-2014 is funded.

AHHA calls for sustained priority support for Aboriginal and Torres Strait Islander health programs including those that encourage collaboration, between Aboriginal community-controlled services and mainstream services, and which develop the capacity and resilience of individuals and communities. There is a particular opportunity through Primary Health Networks to entrench better connectedness with non-Aboriginal and Torres Strait Islander health services at the primary level, but also better planning for the healthcare needs and challenges facing Aboriginal and Torres Strait Islander people.

The 2018 Federal Budget coincides with the planned Federal Government 'refresh' of the Closing the Gap Strategy from mid-2018. The 2018 Federal budget must concentrate resources to the following priorities in order to make significant improvements to Aboriginal and Torres Strait Islander health and Close the Gap in this generation—by 2030.

Institutional racism
For Aboriginal and Torres Strait Islander people, institutional racism in hospitals and health services fundamentally underpins racial inequalities in health. It forms a barrier to accessing healthcare, and must be acknowledged and addressed in order to realise health equality. A matrix has been developed for identifying, measuring and monitoring institutional racism. This simple and cost-effective tool has shown its value for both internal and external assessment (Marrie & Marrie 2014). Validation of the matrix for use in hospitals and health systems across Australia is required prior to deployment. Once validated the matrix should be incorporated into performance information and reporting requirements across the health system.

Aboriginal and Torres Strait Islander representation in the health workforce
The Australian health workforce has insufficient Aboriginal and Torres Strait Islander representation which seriously affects the capacity of the health system to meet the needs of Aboriginal and Torres Strait Islander people (AHMAC 2017). Long term targeted programs are needed to increase representation across the health workforce. Aboriginal and Torres Strait Islander health peak organisation have a critical role in supporting the workforce growth and would benefit from the certainty and efficiency of 5-year funding cycles.

Implementation of the National Aboriginal and Torres Strait Islander Health Plan 2013–2023
The Implementation Plan is a major commitment by the Federal Government and requires adequate resourcing. To achieve this objective the Government should undertake formal costing to identify resourcing gaps, the current funding programs and differentiate between mainstream programs and direct Aboriginal and Torres Strait Islander programs. Additional benefit would be gained by a capacity-building plan for Aboriginal Community Controlled Health Organisations in geographic areas with inadequate services and high levels of preventable illness and death.

11 Closing the Gap prescriptions

Key Recommendation:
- The Closing the Gap PBS Measures are reviewed to enable provision of key medicines to Aboriginal and Torres Strait Islander patients regardless of setting.

Implemented in 2010, the Closing the Gap Pharmaceutical Benefits Scheme (PBS) Measure and Remote Area Aboriginal Health Services s100 program have improved Aboriginal and Torres Strait Islander access to medicines and pharmacy services.

Both Closing the Gap PBS Measures and Remote Area Aboriginal Health Services programs are limited by location and substantial gaps remain around the access of people away from home whether visiting family in a regional town or receiving treatment for serious illness in a metropolitan hospital. This has been highlighted as problematic in the work the AHHA is conducting in partnership with the Heart Foundation with hospitals participating in the Lighthouse Hospital Project[1].

Possible solutions include:
- Enabling hospitals discharging patients registered as Closing the Gap patients to access the Closing The Gap funding necessary to provide a complete medication supply and Dose Administration Aids as required;
- Revising registration of patients for Closing the Gap PBS co-payment measure, to also include patients typically accessing medicines through Remote Area Aboriginal Health Services, to enable consistent and adequate medicine supply at times of hospital discharge;
- Revising the prescriber categories for Closing the Gap prescriptions to include both Remote Area Aboriginal Health Services and hospitals to enable provision of key medicines to Aboriginal and Torres Strait Islander patients regardless of setting; and
- Adding the provision of Dose Administration Aids to the list of medicines funded through Closing the Gap and s100 remuneration programs to improve the safe adherence of medicines by patients at high risk of medicines misadventure.

[1] Details on the Lighthouse Hospital Project can be found at http://ahha.asn.au/lighthouse/lighthouse-project.

Conclusion

This submission outlines a number of areas of reform to the healthcare system that are achievable with leadership by the Commonwealth Government, working in cooperation with state and territory governments and meso level health service organisations. The way our healthcare system is organised needs to be adapted to more effectively delivery of healthcare services to improve patient care and to achieve system efficiencies.

The Australian Government recognised the importance the Australian public place on universal healthcare with their initiatives announced in the 2016-17 Budget to Guarantee Medicare. The recommendations made in this submission provide the opportunity to build on this expressed commitment to develop a more sustainable, coordinated, accessible and fair healthcare system.

This submission provides a number of practical and necessary recommendations on how this can be achieved with a broad focus on outcomes, coordination of care and specific areas requiring health policy leadership.

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Australian Healthcare & Hospitals Association
Unit 8, 2 Phipps Close

Deakin ACT 2600
PO Box 78

Deakin West ACT 2600
P: 02 6162 0780
F: 02 6162 0779
E: admin@ahha.asn.au
W: ahha.asn.au
@AusHealthcare
facebook.com/AusHealthcare
linkedin.com/company/australian-healthcare-and-hospitals-association
ABN: 49 008 528 470