AHHA Submission to the Scope of Practice Review - Issues Paper 1 Public Submissions

8 March 2024

OUR VISION

The best possible healthcare system that supports a healthy Australia.

OUR PURPOSE

To drive collective action across the healthcare system for reform that improves the health and wellbeing of Australians.

OUR GUIDING PRINCIPLES

Healthcare in Australia should be:

Outcomes-focused
Evidence-based
Accessible
Equitable
Sustainable

OUR CONTACT DETAILS

Australian Healthcare and Hospitals Association (AHHA)
Ngunnawal Country
Unit 8, 2 Phipps Close
Deakin ACT 2600

Postal Address
PO Box 78
Deakin West ACT 2600

Phone
+61 2 6162 0780

Email
admin@ahha.asn.au

Website
ahha.asn.au

Socials
https://www.facebook.com/Aushealthcare/
https://twitter.com/AusHealthcare
https://www.linkedin.com/company/australian-healthcare-&-hospitals-association

INTRODUCTION

The Australian Healthcare and Hospitals Association (AHHA) welcomes the opportunity to contribute to the Department of Health and Aged Care's Scope of Practice Review - Issues Paper 1 Consultation.

This submission builds on consultation undertaken with health system leaders in developing a blueprint for health reform towards outcomes-focused, value-based health care, and AHHA's operating model of continuously listening to and engaging with the experiences and evidence from our members and stakeholders, as we contribute to the evolution of our health system.

ABOUT THE AHHA

For more than 70 years, AHHA has been the national voice for public health care, maintaining its vision for an effective, innovative, and sustainable health system where all Australians have equitable access to health care of the highest standard when and where they need it.

As a national peak body, we are uniquely placed, in that we do not represent any one part of the health system. Rather, our membership spans the system in its entirety, including – public and not-for-profit hospitals, PHNs, community, aged care and primary healthcare services.

Our research arm, the Deeble Institute for Health Policy Research connects universities with a strength in health systems and services research, ensuring our work is underpinned by evidence.

In 2019, AHHA established the Australian Centre for Value-Based Health Care, recognising that a person's experience of health and health care is supported and enabled by a diverse range of entities, public and private, government and non-government. The Centre brings these stakeholders together around a common goal of improving the health outcomes that matter to people and communities for the resources to achieve those outcomes, with consideration of their full care pathway.

Through these connections, we provide a national voice for universal high-quality health care. It is a voice that respects the evidence, expertise, and views of each component of the system while recognising that siloed views will not achieve the system Australians deserve.

OUR RESPONSE

LEGISLATION AND REGULATION

1. **What do you believe are the key legislative and regulatory reforms which have the potential to most significantly impact health professionals' ability to work to full scope of practice? (For example, harmonisation of specific legislation between jurisdictions, or regulating health professionals differently.)**

Health practitioner legislation and regulation must ensure the community has access to a safe and high-quality health workforce, across all professions, in a health system which meets the needs of all Australians and supports equity in achievement of health outcomes.

AHHA supports legislative and regulatory reforms to increase health professionals' ability to work to full scope of practice that are, first and foremost, *driven by consumer need* as opposed to driven by interests of professional groups.

Reforms that fail to put consumer and community interests first will be perceived as serving the practitioner's economic interest, reinforcing professional norms, behaviours and attitudes, perpetuating existing domains of professional legitimacy, and/or protecting the profession from declining appreciation of its importance. Historically, such perceptions have, rightly or wrongly, dominated discussions of policy reform to scope of practice, drawing focus away from the needs of the public and consumers. As such, there must be a mechanism within legislation and/or regulation to ensure consumer and community need is a priority focus.

Due to the evolving nature of health care and need to embed innovations to scope of practice sustainably into our health system, we propose that reforms use a value-based health care framework and consider the recommendation included in the consultation on Health Technology Assessment (HTA) policy and methods: to incorporate an independent horizon scanning activity. Such activity would be undertaken to identify potential scope of practice changes and a subsequent priority assessment process to guide the implementation of reforms nationwide. See the *Horizon Scanning and Early Assessment HTA Policy and Methods Review - Paper 2*[1] for further details.

Ultimately, this would be a mechanism for the identification or nomination of reform to workforce models (and related legislation, regulation or other policy), followed by a mechanism of assessment, across outcomes, resources and context. Then ultimately, depending on the findings of the assessment, implementation across Australia (or specific regions with identified need, e.g. rural and remote classified areas).

This would differ from current practice as currently, there is no mechanism to scale and spread trials and projects to sustainably improve care, as identified in the Final Report of the Mid-Term Review of the National Health Reform Agreement. The Mid-term review went on to make a corresponding recommendation for an Innovation Agency to be established, to ensure responsibility and resourcing is assigned for innovations that address consumer need are embedded in practice. Embedding responsibility is critical, providing a mechanism for transparency and accountability to both action and follow through change.

A horizon scanning and early assessment program will need to work closely with not only consumers and clinicians, but health services and stewards, to understand the pathways of care and the investments across the care pathway to ensure equitable access and efficient resourcing. Proposals to such a program would need to prioritise health outcomes, costs, access and equity.

As our health system adapts to increasingly complex and emerging challenges, and as a result we demand more of our dedicated and talented workforce, this discussion about scope of practice will arise time and time again, as it has for so many years. Embedding a process for scope of practice reform to allow for the assessment and implementation of innovative models of addressing community need, like that of HTA, will help to address this issue in a way that is sustainable, flexible and has impact.

2. **A risk-based approach to regulation names core competencies, skills or knowledge capabilities required to authorise a health professional to perform a particular activity, rather than relying solely on named professions or protected titles. To what extent do you think a risk-based approach is useful to regulate scope of practice?**
    a. **<u>To a great extent</u>**
    b. **Somewhat**
    c. **A little**
    d. **Not at all**

3. Please provide any additional comments you have on the risk-based approach to regulation.

AHHA supports a risk-based approach to regulation that shifts focus to activity or tasks, so as to move towards models of care that places a greater emphasis on the appropriateness of the activity or task provision above the profession of the provider. This is necessary to bring regulation in line with contemporary community needs and services.

4. What do you see as the key barriers to health professionals' authority to make referrals across professions?

The Deeble Institute for Health Policy Research Issues Brief no.38 Optimising health care through specialist referral reforms[2] provides an analysis of the need to reform Australia's specialist referral system, which has received limited scrutiny since the 1970s. In the brief, Prime et al. acknowledge that to transition to a system focusing on the appropriateness of the referral over the profession of the referrer, which optimises health care for patients in terms of cost and access, 'will require a well co-ordinated, effective and efficient referral system that facilitates the evidence-based and linear transfer of care from one clinician to another within a highly interoperable and collaborative healthcare system'[3].

Therefore, AHHA supports the following solutions proposed in the brief:

- 'More consistent data on longitudinal health service utilisation trends across service providers and jurisdictions is needed to inform how services must be restructured and legislation adapted, to improve patient throughput'[4].
- 'Invest in health system interoperability and mandate real-time health information exchange between multidisciplinary care teams to facilitate high quality, coordinated and continuous care'[5].

Importantly, Prime et al. note that without ongoing oversight and monitoring of referral rules to ensure correct application and that the rules are achieving intended outcomes, consumers 'will continue to be negatively impacted by outdated referral pathways leading to increased costs and delayed care'[6]. This could also be incorporated in the horizon scanning and early assessment program discussed in response to question one.

The availability and dissemination of information will also be a key barrier to introducing the ability of other health professionals to make referrals, and must be considered in the shifts to how referrals are made. This includes:

- Health professionals' awareness of other services to refer to.
- Consumer awareness and literacy on which health professionals can make referrals to ensure new referral pathways are utilised.
- Health services and leaders understanding of full pathways of care with the introduction of new referral pathway opportunities.

EMPLOYER PRACTICES AND SETTINGS

1. **What changes at the employer level would you like to see to enable health professionals to work to full scope of practice? (For example, changes to credentialling, practice standards, clinical governance mechanisms or industrial agreements)**

The Australian Commission on Safety and Quality in Health Care's National Safety and Quality Primary and Community Healthcare Standards and accreditation mechanism could be implemented more widely in order to facilitate models of care that allow health professionals to work to full scope of practice to deliver consumer-centred care. Primary Health Networks (PHNs) could support this implementation with appropriate resourcing attached.

The intelligence PHNs hold about the barriers and challenges employers face in enabling health professionals to work to full scope of practice could be better utilised in policy development. Barriers to PHNs undertaking this role was identified in the Mid-Term Review of the National Health Reform Agreement:

> 'While the current Addendum highlights the importance of considering and consulting with PHNs, it falls short of recommending formal participation or establishing structures for planning and implementation. Consequently, PHNs are often overlooked in the initial stages of planning and their input is sought too late in the process to have a meaningful impact'[7].

The report goes on to state:

> 'Currently, PHNs operate with constrained and inflexible budgets, limited authority and capacity to plan, coordinate, and influence the development of integrated healthcare services and workforce planning.
>
> That said, there are a number of high performing PHNs that have demonstrated the positive impacts these structures can have on communities at a local level and shown their ability to progress reform activity in the primary care space'[8].

Utilising and resourcing PHNs to effectively feed information up to the national level on why employers are or are not changing behaviours could lead to place-based approaches to addressing local issues, such as place-based clinical governance arrangements, or information that could be used to reform national policy if deemed appropriate.

2. **Which particular activities or tasks within health professionals' scope of practice would you particularly like to see increased employer support for?**

AHHA would particularly like to see increased employer support for health professionals to understand and manage risk through the introduction of new models of care.

Clinical risk management, traditionally focused on patient safety and reducing errors, faces growing complexity due to rapid evidence publication, technological advancements, cybersecurity threats, and shifting regulatory and funding landscapes. Additionally, in resource constrained healthcare settings, reallocating and disinvesting from low-value to high-value care is crucial for effective risk

management[9]. All staff must integrate risk management into their daily tasks, while healthcare professionals must also assess care delivery processes, structures, and environments[10].

3. **What can employers do to ensure multidisciplinary care teams are better supported at the employer level, in terms of specific workplace policies, procedures, or practices?**

There is a relatively poor evidence base for the evaluation of scope of practice changes[11]. Some 'successful' changes to scopes and roles are reported. However, success is often related to implementation and acceptance, rather than impact on outcomes and cost. Where impact is measured, it is often short-term rather than long-term impact. Scope of practice changes tend to be more widely accepted when the health profession transferring the scope has accepted that their profession does not have the capacity or interest in continuing to provide these tasks[12]. This means many scope of practice changes are proposed in a hostile environment. Punctuated equilibrium theory can be used to explain why the scope of practice changes during COVID-19 pandemic were successful[13].

Achieving changes to scope of practice is reported to be achieved through three mechanisms: *interprofessional collaboration* (i.e. negotiated agreement among different health practitioners), *delegation* (i.e. where responsibility is assigned to another practitioner, but accountability remains with the delegator) or *substitution* (i.e. where both responsibility and accountability are transferred)[14].

Competency frameworks may have a role to play in scope of practice. While professional development (particularly for registration purposes) is the responsibility of the individual practitioner, employers also have an interest in the development and advancement of health professionals. Health service managers have been reported to use competency-based career frameworks for[15]:

- Conducting service reviews
- Workforce planning and development
- Redesigning or defining roles
- Appraisal, self-appraisal and personal development planning
- Conducting reviews of skill mix
- Developing and delivering training programs or qualifications.

These mechanisms can all be used to support multidisciplinary care teams, but external influences will enable their effective use (such as those identified as themes in this submission; legislation and regulatory, funding, technology and education and training).

It has been suggested that the development of a whole-of-workforce competency framework for the Australian health workforce would facilitate such changes, increasing workforce flexibility to meet new and emerging demands on the health system. The Allied Health Leadership and Advancing Practice Framework[16] (we note is identified in the Issues Paper), which AHHA prepared in collaboration with Queensland Health, is an example of a framework aiming to develop non-clinical skills that are applicable across multiple professions and which can foster multidisciplinary team based care.

EDUCATION AND TRAINING

1. **What are the key barriers health professionals experience in accessing ongoing education and training or additional skills, authorities or endorsements needed to practice at full scope? You may select multiple responses.**
    a. **Availability of learning institutions**
    b. **Employer support for learning**
    c. **Availability of supervision and mentoring**
    d. **Quality of training**
    e. **Time burden**
    f. **Other**

2. **If you chose 'other', please provide details.**

The way education and training providers are required to meet continuing professional development (CPD) accreditation requirements for their education and training programs is a barrier on the supply side of education and training.

CPD accreditation requirements are set by each professions' regulatory board separately and the requirements and assessment processes are not coordinated or streamlined across boards. This puts a burden on the education provider to apply to be accredited separately, even when their education and training program is applicable to multiple professions, and often results in providers only applying to be accredited with one or two boards.

This impacts on health professionals' ability to identify the right programs to meet their education and training needs, as they are incentivised to select programs that are CPD accredited with their board. There should be a shared process for education and training programs that span multiple professions to be accredited for CPD by multiple boards.

Further, AHHA supports the opportunities for improvement set out in the Consultations Issues Paper, including the:

- harmonisation of education and training requirements for the same competency between different professions,
- establishment of a nationally consistent approach in promoting and implementing common interprofessional competencies,
- promotion of multi-professional learning; and
- ensuring ongoing education and training are accessible.

FUNDING

1. **Are you aware of specific instances where funding and payment could be provided differently to enhance health professionals' ability to work to full scope of practice? Please provide specific examples.**

If funding and payments were designed based on outcomes, then health professionals' ability to work to full scope of practice would be enhanced to meet consumer needs in the areas where activity based funding is failing to do so.

In rural and remote areas of Australia, there is often a single workforce working across the health, aged care and NDIS sectors. The current siloed, complex funding and payment mechanisms are creating barriers to the delivery of integrated care to meet local needs. In addition, the administrative burden that the reliance on several funding and payment mechanisms places on services and providers can restrict health professionals' ability to work to full scope of practice.

The design of commissioning and/or service contracts is one example of an instance where funding and payment could be provided differently to better utilise scope of practice and the resources available in rural and remote areas. AHHA has heard that contracts can prescribe which specific professions must deliver a particular service to a community, with little flexibility to allow for the same or similar service to be delivered by different professions when workforce supply makes it impossible to meet those profession requirements. This results in the community not receiving the service at all, or the contract being awarded to a service without existing local understanding or relationships with the community, including First Nations communities.

Healthy Outback Communities (HOC) is an example of a grassroots effort to address local need through a collaboration of local service providers. This new, collaborative model of health and social care aims to improve access, equity, and outcomes in the very remote area of Western Queensland, in a region that spans almost 220,000 sq km, equivalent to the size of Victoria. With 1,100 residents and the absence of resident GPs, pharmacist and dedicated healthcare professionals, this local community has taken matters into their own hands. This type of bottom up, place-based approach must be supported at a national level.

The Transport Accident Commission is also leading significant work in incentivising models of care that are data-driven to achieve better outcomes for the resources used.

What is needed to enable this are funding and payments that support flexibility in how the local workforce is used to support place-based models of care, where outcomes are defined and appropriate clinical governance is prioritised. This relates to the need to provide further authorisation, influence and resourcing to PHNs, as discussed previously in this submission.

Other well-known examples relate to restrictions on nurses and nurse practitioners from working to full scope of practice due to MBS rules.

2. **Which alternative funding and payment type do you believe has the greatest potential to strengthen multidisciplinary care and support full scope of practice in the primary health care system?**
    a. **Block funding**
    b. **Bundled funding**
    c. **Blended funding**
    d. **Capitation**
    e. **Salary**

f. Program grants
g. Other
h. None

3. If you selected 'other', please provide details.

AHHA supports the use of value-based payment models. Value-based payment models seek to motivate providers and clinicians to deliver best practice care, improve outcomes and reduce costs through financial incentives[17]. Value-based payment include, but are not limited to, pay-for-performance, capitation, bundled payments and accountable care organisations. The Deeble Institute for Health Policy Research Issues Brief no.49 A roadmap towards scalable value-based payments in Australian healthcare[18] explores the challenges and advantages of moving ahead with a health funding model that includes value-based payments.

In the brief, Cutler notes that 'bundled payments can potentially provide greater incentives to better coordinate care across multiple providers, as care coordination could lower costs but is not often delivered within a fee-for-service model'[19].

However, AHHA would caution against an all-in approach to one individual funding or payment type, as no single payment model will provide the solution Australia's health system needs. Each of the listed suggestions in this question have pros and cons. Addressing the challenge of scope of practice extends beyond the health funding and payment apparatus – such an isolated focus will ultimately result in a different set of policy problems.

A 2024 scoping review of the use of financial incentives for integrated care that specifically analysed evidence for bundled payments, pay for coordination, pay for performance, and shared savings, concluded that 'all four types of financial incentives may promote integrated care but not in all contexts and settings' and that there was a 'scarcity of evidence' to draw firm conclusions about the transferability of financial incentives to other contexts[20].

AHHA agrees with the assertion that:

> 'Implementing a value-based payment model in isolation will lead to duplication and missed opportunities to share learnings and iteratively improve value-based payment models.
>
> The likelihood of developing a program of successful value-based payment models will be substantially greater if state, territory and federal governments develop a structured and supportive policy and institutional framework around the intent to trial and evaluate ongoing value-based payment models nationally'[21].

Evidence and analysis does indicate that the key to successfully implementing new funding models that better integrate health care is to establish (1) infrastructure to enable interoperable electronic record systems, (2) primary care outcomes, costs and process data collection and analysis, and (3) workforce support in the form of financial support, training and clear communication and guidelines[22,23].

Cutler makes four recommendations in the Issues Brief towards establishing this structured and supportive policy and institutional framework:

I. Develop a cohesive national vision and ambitious national 10-year plan for value-based payment integration into the Australian healthcare system.
II. Create an independent national payment authority to implement the national plan through strong relationships with relevant federal government agencies and with state and territory governments. (AHHA notes that this could be another role for the Innovation Agency or a role for the Independent Aged Care Hospital Pricing Authority (IHACPA)).
III. Improve cost and outcome data collection, analysis and access among government and providers, aiming for seamless, low cost collection and effective flow of information.
IV. Support provider education, training and innovation by identifying and promoting best practice care, developing provider assistance tools and training packages, and promoting peer-to-peer learning[24].

4. **How do you believe your selected funding type(s) could work to resolve barriers to health professionals working to full scope of practice?**

See responses to previous two questions.

5. **To what extent do you believe alternative funding policy approaches create risks or unintended consequences?**

    a. **<u>To a great extent</u>**
    b. **Somewhat**
    c. **A little**
    d. **Not at all**

6. **How do the risks of alternative funding policy approaches compare to the risks of remaining at status quo?**

As noted in Cutler's Issues Brief:

> 'Value-based payments shift financial risk from payer to provider. Other risks may also increase for providers, such as strategic risk, operational risk and clinical risk, as providers change their business and care models. Yet there are potential benefits to providers from participating in value-based payments. Providers can capture greater market share by delivering better quality, or participate in financial rewards from reducing costs. Positive externalities, such as improved information technology and better use of data can also prevail over current practices.'[25]

TECHNOLOGY

1. **How do you think technology could be used better or differently in primary health care settings to enable health professionals to work to full scope?**

Technology could be used to share information between providers and services to support desired clinical workflows, improve the use of electronic health records, and coordinate the development and monitoring of shared care plans (rather than multiple care plans developed independently). This would create efficiencies by preventing duplication, reducing time and therefore costs, enhance the patient journey of care and allow for real-time data to inform decision-making.

2. **If existing digital health infrastructure were to be improved, what specific changes or new functions do you think are most necessary to enable health professionals to work to full scope?**

Digital health infrastructure must enable interoperability to allow information sharing and real-time record keeping. Infrastructure must support the collection of outcomes and costs data to facilitate the delivery of value-based health care and to inform care innovation and/or improvements. In addition, infrastructure should support integration of data being generated through medical and technological advances (e.g. genomics, wearables, biosensors, remote health monitoring systems and data sources outside the health system) and the sharing of information for team-based models of care.

3. **What risks do you foresee in technology-based strategies to strengthen primary health care providers' ability to work to full scope, and how could these be mitigated?**

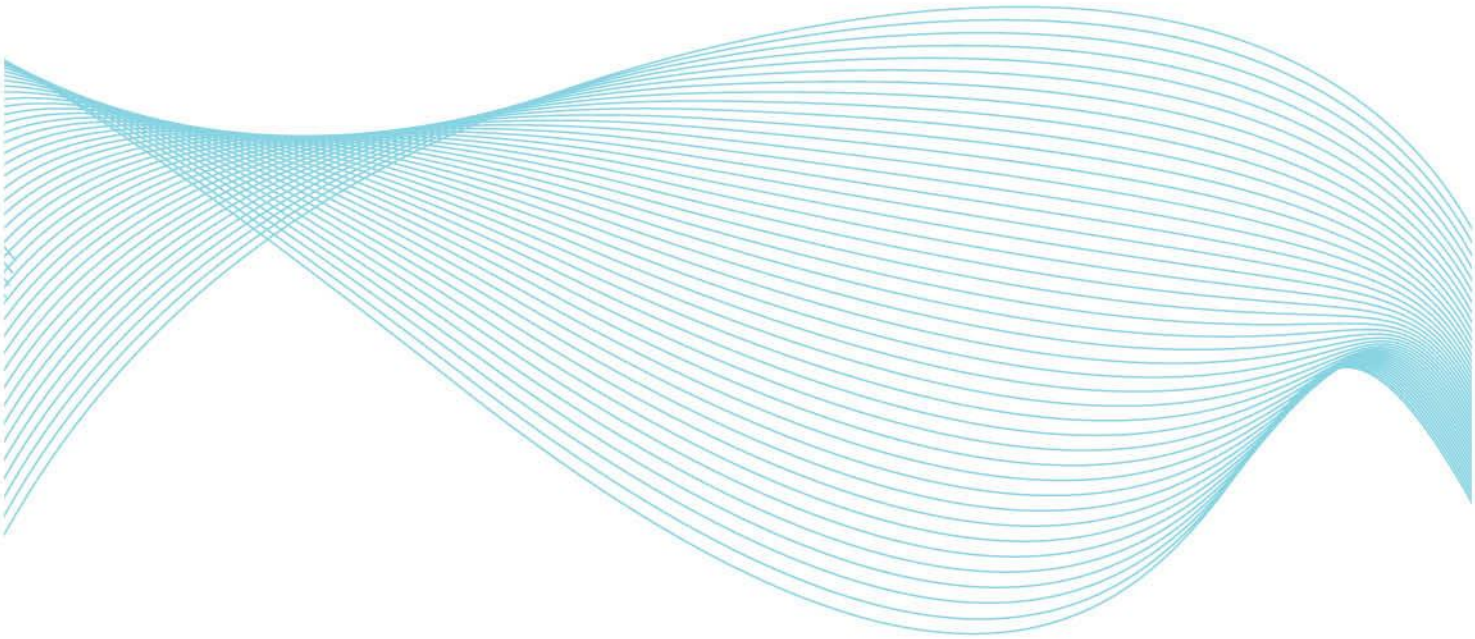
States and territories have digital health strategies that provide a shared direction for investment in the information and communication technology (ICT) architecture required for transforming the way health care is delivered. They are increasingly moving to single electronic health records for the hospitals and health services in their jurisdictions, recognising that capturing and effectively using clinical information is important in ensuring quality, safe and sustainable healthcare services. The records of general practices and other primary care providers are typically not incorporated, although some jurisdictions have developed systems to allow GPs to view patient's hospital records to support continuity of care[26].

The ICT architecture within the states and territories have also been planning for integrating the increasing amounts of data being generated through medical and technological advances (e.g. genomics, wearables, biosensors, remote monitoring systems and data sources outside the health system) and how these can be used to inform care[27].

Successful implementation of electronic health records and other technological solutions is dependent on a broad range of organisational, human and technological factors and significant challenges are accepted. General practices and other primary care providers are typically distinct small business entities, and implementation of the Digital Health Blueprint and Action Plan 2023-2033 will be an important enabler in strengthening providers' ability to work to full scope.

REFERENCES

[1] Parsons J, Milverton J, Ellery B, Tamblyn D, Merlin T. 2023. Horizon scanning and early assessment. Health Technology Assessment Policy and Methods Review. Canberra, ACT: Australian Department of Health and Aged Care.
[2] Prime S, Gardiner C and Haddock R. 2020. Optimising health care through specialist referral reforms. Issues Brief no. 38, Deeble Institute of Health Policy Research. Canberra, ACT.
[3] Ibid, page 26.
[4] Ibid, page 11.
[5] Ibid, page 28.
[6] Ibid, page 28.
[7] Huxtable R, 2023. Mid-Term Review of the National Health Reform Agreement Final Report. Department of Health and Aged Care. Accessed at: https://www.health.gov.au/sites/default/files/2023-12/nhra-mid-term-review-final-report-october-2023.pdf, page 67.
[8] Ibid, page 68.
[9] Calabrò GE, La Torre G, de Waure C, et al. 2018. 'Disinvestment in healthcare: an overview of HTA agencies and organizations activities at European level', *BMC Health Services Research*, vol.18, no.148. Accessed at: https://doi.org/10.1186/s12913-018-2941-0
[10] Department of Health, Wester Australia, 'Clinical Risk Management Guidelines: A best practice guide' Patient Safety Surveillance Unit, Accessed at: https://ww2.health.wa.gov.au/~/media/Files/Corporate/general-documents/Quality/PDF/WAHealth-Clinical-Risk-Management-Guidelines.pdf
[11] Leggat S. 2014. Changing health professionals' scope of practice: how do we continue to make progress? Issues Brief, Deeble Institute for Health Policy Research. Canberra, ACT.
[12] Ibid.
[13] Amri MM, Drummond D. 2021. 'Punctuating the equilibrium: an application of policy theory to COVID-19', *Policy Design and Practice*, vol.4, no.1: 33-43. Accessed at: https://doi.org/10.1080/25741292.2020.1841397
[14] Leggat S. 2014.
[15] Brownie S, et al. 2011. Exploring the literature: Competency-based education and training and competency-based career frameworks. Adelaide: University of Queensland Node of the Australian Health Workforce Institute in partnership with Health Workforce Australia.
[16] Queensland Government. Allied Health Leadership and Advancing Practice Framework. Queensland Health. 2022. Accessed at: https://www.health.qld.gov.au/__data/assets/pdf_file/0027/1210995/AHLAP-Framework.pdf
[17] Cutler H. 2022. A roadmap towards scalable value-based payments in Australian healthcare. Issues Brief no. 49, Deeble Institute of Health Policy Research. Canberra, ACT.
[18] Cutler H. 2022.
[19] Ibid, page 16.
[20] Yordanov D, Oxholm AS, Prætorius T, & Kristensen SR. 2024. 'Financial incentives for integrated care: A scoping review and lessons for evidence-based design', *Health Policy*, vol.141: 104995. Accessed at: https://doi.org/10.1016/j.healthpol.2024.104995
[21] Cutler H. 2022.
[22] Yordanov D, Oxholm AS, Prætorius T, & Kristensen SR. 2024.
[23] Cutler H. 2022.
[24] Ibid.
[25] Ibid.
[26] Queensland Health 2022, Health provider portal, viewed 07 March 2024, Accessed at: https://www.health.qld.gov.au/clinical-practice/database-tools/health-provider-portal
[27] NSW Health 2024, eHealth strategy for NSW Health 2016-2026, viewed 07 March 2024, https://ehealth.nsw.gov.au/__data/assets/pdf_file/0007/725956/eHealth-Strategy-for-NSW-Health-2016-2026.pdf



OUR CONTACT DETAILS

Australian Healthcare and Hospitals Association (AHHA)
Ngunnawal Country
Unit 8, 2 Phipps Close
Deakin ACT 2600

Postal Address
PO Box 78
Deakin West ACT 2600

Phone
+61 2 6162 0780

Email
admin@ahha.asn.au

Website
ahha.asn.au

Socials
https://www.facebook.com/Aushealthcare/
https://twitter.com/AusHealthcare
https://www.linkedin.com/company/australian-healthcare-&-hospitals-association