

Friday, 26 September 2014

Committee Secretary  
Senate Select Committee on Health  
PO Box 6100  
Parliament House  
Canberra ACT 2600

Submission to the Senate Select Committee on Health

Dear Madam/Sir,

Thank you for your invitation to make a submission to the Senate Select Committee on Health with regards to its inquiry into health policy, administration and expenditure.

St Vincent's Health Australia is the nation's largest not-for-profit Catholic health and aged care provider. Spanning the eastern seaboard, St Vincent's Health Australia is a clinical, research and education leader working in private hospitals, public hospitals and aged care services.

This submission by St Vincent's Health Australia addresses the following terms of reference:

- the impact of reduced Commonwealth funding for hospital and other health services provided by state and territory governments, in particular, the impact on elective surgery and emergency department waiting times, hospital bed numbers, other hospital related care and cost shifting;
- the impact of additional costs on access to affordable healthcare and the sustainability of Medicare;
- the impact of reduced Commonwealth funding for health promotion, prevention and early intervention;
- improvements in the provision of health services, including Indigenous health and rural health;
- the interaction between elements of the health system, including between aged care and health care;
- health workforce planning; and,
- any related matters.

We would be pleased to appear in person and provide further support to the Senate Select Committee on Health regarding these important matters.

Yours sincerely,



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**ST VINCENT'S  
HEALTH AUSTRALIA**

UNDER THE STEWARDSHIP OF MARY AIKENHEAD MINISTRIES

**Submission to Senate Select Committee on  
Health inquiry into health policy,  
administration and expenditure**

**Submission:**

**25 September 2014**

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## 1. About St Vincent's Health Australia

St Vincent's Health Australia (SVHA) is the nation's largest Catholic not-for-profit health and aged care provider. Our services comprise 27 facilities along the east coast of Australia including six public hospitals, eight private hospitals, 13 aged care facilities and four co-located research institutes Victor Chang Cardiac Institute, Garvan Institute of Medical Research, O'Brien Institute, and St Vincent's Institute of Medical Research.

From the health services established by the Sisters of Charity in 1857 at Woolloomooloo in Sydney, St Vincent's Health Australia has grown to encompass a diverse range of tertiary services including: acute medical and surgical services; emergency and critical care; aged and sub-acute care; diagnostics; mental health; correctional health; palliative care; residential care; research and education.

St Vincent's Health Australia operates more than 2,500 hospital beds, 1,100 aged care places, employs over 16,000 staff, works with over 2,500 medical practitioners and draws on the talents of over 1,300 generous volunteers. Each year we provide care to more than 250,000 inpatients and over a million episodes of ambulatory care through our outpatient services.

We are a clinical and education leader and have a national and international reputation in various fields of medical research. Our areas of expertise crosses a large domain including: heart lung transplantation; bone marrow transplantation; cardiology; neurosurgery ;cancer; HIV medicine; respiratory medicine; mental health; drug and alcohol services; aged psychiatry; homeless health care and Aboriginal health.

We have significant University affiliations with the University of Sydney, University of New South Wales, University of Melbourne, Australian Catholic University, University of Southern Queensland, University of Wollongong, University of Tasmania, University of Notre Dame and others.

It is the intention of St Vincent's Health Australia to remain at the service of the Australian community well into the future, reaching out particularly to the most vulnerable people in the Australian community, and to continue our strong held belief that a society is only as healthy as the least healthy among us. Our shared responsibility for the society which privileges most, but cripples some, calls us to act.

## 2. Senate Select Committee on Health Terms of Reference

Inquiry into health policy, administration and expenditure, with particular reference to:

- a. the impact of reduced Commonwealth funding for hospital and other health services provided by state and territory governments, in particular, the impact on elective surgery and emergency department waiting times, hospital bed numbers, other hospital related care and cost shifting;
- b. the impact of additional costs on access to affordable healthcare and the sustainability of Medicare;
- c. the impact of reduced Commonwealth funding for health promotion, prevention and early intervention;
- d. the interaction between elements of the health system, including between aged care and health care;
- e. improvements in the provision of health services, including Indigenous health and rural health;
- f. the better integration and coordination of Medicare services, including access to general practice, specialist medical practitioners, pharmaceuticals, optometry, diagnostic, dental and allied health services;
- g. health workforce planning; and
- h. any related matters.

### 3. Executive Summary

St Vincent's Health Australia's mission seeks not only to transform the lives of those in direct contact with our services, but to transform the delivery of health care itself. In partnership with all levels of government, non-government and not for profit organisations, we advocate for just and accessible health care for all in the community.

As a major national health service provider we also acknowledge that health care represents a growing proportion of public and individual budgets, which means that efficiency, value for money and outcomes are important. Planning our response to the health and aged care needs of Australians today and in the years ahead therefore requires that collectively we act strategically and that short-termism and the pressure of the federal budget, do not crowd our attention and planning for the long term.

Taking the long-term view, we know that there are significant changes impacting on the health of Australians, particularly the growing and ageing of the population and the emergence of the 'epidemic of chronic disease'. These are substantial challenges that already place pressure on the current organisation and funding of Australia's health system. Although additional or shifting investments will be required to meet some of these challenges, as has been demonstrated in the measures introduced in the 2014-15 Commonwealth Budget, the development of a long-term health reform plan must also move beyond the challenges of today and take a visionary approach in identifying what the health system should look like over the next twenty years. Addressing the challenges needs concerted action by Commonwealth and state governments, involving the public and private sectors, hospital and community services, and crossing traditional funding boundaries. This can only occur when a long term strategic vision is identified and a framework is defined where the roles and extent of responsibility is clearly specified, so there can be clear political (and bureaucratic) accountability for meeting the public's expectations not only for managing funding, but also accountability on achieving health outcomes. Importantly, we are signalling our view that this Inquiry recognise that the debate for the longer term strategic solution to health care reform has only just commenced, and will no doubt complement the upcoming discussions that will be generated as part of the Commonwealth's White Paper on the Reform of the Federation.

As part of the health policy debate, St Vincent's Health Australia would also urge the Inquiry to reflect upon the fact that the health system cannot be held wholly responsible for our health – it is a shared responsibility across all agencies, government, non-government, industry and individuals that contribute to the health of a society. As a nation we need to proactively build partnerships across other sectors (including education, housing, transport, workplaces and local government) if we are to address the social determinants of health that directly impacts the health of this nation. In addition, it is imperative that we operate from the fact that health is not "merely the absence of disease": the health and aged care system has an important function in protecting and promoting health and intervening before the onset of a chronic or debilitating condition occurs. This ranges from providing services to individuals and groups to broader, whole of population interventions. This is why, prevention has to be core to our health care system and requires policy to give at least the same priority to long term gains as accorded the urgent and immediate.

The Inquiry also provides an opportunity to focus on ensuring public funding of health care is both sufficient and efficiently managed to deliver the highest quality of health care to all Australians. We urge that particular attention, however, needs to be given to ensuring that any barriers in access to health care for socioeconomically disadvantaged Australians are continuously monitored and removed, such that they also enjoy the same health care access, and health care outcomes, as the



most advantaged Australians. As an organisation we are seeing widening gaps in both health outcomes and ability to access health care that are being experienced by an increasing number of individuals within our local community; this goes against our values as a Catholic organisation of caring for the poor and vulnerable. This is why St Vincent's Health Australia is proactively looking at a number of collaborative partnerships both within and outside the health system to meet this demand, and would welcome an opportunity to share our learnings on some key opportunities where there could be better interaction and efficiencies between the elements of the health system and beyond.

Finally, it is our hope and our intention that as a nation we would continue to build on the strengths of the existing system and ensure that health care is not seen as a privilege, but a right and a requirement to protect the life and dignity of every person.

## **SVHA RECOMMENDATIONS**

### **Terms of Reference (a): Reduced Commonwealth funding for hospital and other health services provided by state and territory governments**

1. That the Commonwealth develop a long term strategic vision for health and that the goals of the health system should be considered in the context of the White Paper on the Reform of the Federation and the White Paper on the Reform of Australia's Tax System, with a particular focus on:
  - Removing the jurisdictional inefficiencies and structural barriers associated with the divided health care responsibilities of our State and Federal governments in order to:
    - Realign the healthcare portfolio structure with population health management and outcomes-based incentives that is coordinated across the spectrum from prevention to primary and acute care, community care and aged care.
    - Reduce the gradient of health inequity endured by the most socially disadvantaged.
    - Introduce cost effective ways to maximise the health outcomes of the community, particularly those of national focus such as rates of diabetes, obesity and cardiovascular disease and those impacting most directly on poor and vulnerable communities.

### **Terms of Reference (b): Additional costs on access to affordable healthcare and the sustainability of Medicare**

2. That the Senate Select Committee examines the recently released Community Affairs References Committee report into out of pocket costs in Australian healthcare and adopt the following recommendations, which St Vincent's Health Australia supports:
  - That the Government should not proceed with further co-payments.
  - That the Government undertake a comprehensive review of the impact of existing co-payments on individuals' access to health services and health outcomes. The review should pay particular attention to the impact on the most vulnerable groups in the community.
  - That the Government review the impact and effectiveness of existing safety nets to ensure that current safeguards provide adequate protection to the most vulnerable in the community.
  - That the Government review the Pharmaceutical Benefits Scheme to identify areas where efficiencies can be gained, with particular reference to the following areas:

- current procurement and pricing structures, with particular reference to examining benchmarking as a mechanism to explore the extent to which savings could be achieved;
  - effective monitoring and review of GP prescribing practices to ensure dispensed medications are cost effective and evidence based; and
  - evaluation of the prevalence of patient non-adherence to prescribed medication, with particular reference to identifying reasons for non-adherence.
- That the Government review existing models for funding and delivery of primary healthcare with a view to identifying opportunities for improved service delivery and health outcomes.
3. Oppose the introduction of:
- Patient co-payment introduced for general practice consultations, pathology, diagnostic imaging and emergency departments, and
  - Medicine co-payments increased and safety net income thresholds increased under the PBS
- on the basis that St Vincent's Health Australia considers such measures as regressive, placing the biggest financial burden on low income people who already experience the greatest burden of illness and disease.
4. That an ongoing monitoring program be put in place to prevent adverse consequences in health outcomes being experienced by socioeconomically disadvantaged Australians. Such a monitoring program should be underpinned by a commitment to remedy any adverse consequences that might become apparent.
5. That a study is taken to identify why health consumers preferentially choose emergency departments for conditions that could be managed in the primary care setting to assist with the development of policy to encourage the correct use of primary care and emergency services. Such a study would need to be conducted periodically to gauge any consumer changes based on the introduction of a co-payment on primary health care services.
- The study should have a particular focus on patients seeking alternatives to primary care due to unaffordability and unavailability, this being particularly significant for chronically homeless individuals, people with drug and alcohol addictions and people suffering from mental health issues.
6. That a study is conducted to establish the cost benefit in implementing and delivering emergency department co-payments and to investigate the flow on costs to the public hospital sector; and, examine what effect co-payments may have on individuals from lower socio-economic groups who have lower life-expectancy and overall poorer health.

**Terms of Reference (c): Commonwealth funding for health promotion, prevention and early intervention**

7. That the Commonwealth Government adopt as a fundamental principle underpinning its health funding strategies that evidence-based long-term health promotion, prevention and early intervention programs have the greatest potential to significantly reduce disease and disability and thereby reduce the economic burden on the health care system.
8. That long-term, bipartisan funding commitments be made for health promotion, prevention and early intervention and that all such programs have a specific focus on the poor and vulnerable and marginalised communities who experience worse health outcomes, worse quality of life, and lower life expectancy than those in higher socio-economic groups.
9. That the Commonwealth Government urgently address the unsustainable economic and social cost burden caused by the misuse of alcohol, together with very significant community concern about alcohol-fuelled violence, by convening a National Alcohol Summit to develop a broader

national policy framework on how to improve the health, social and economic outcomes for Australians by reducing the harmful effects of alcohol in society. The Summit agenda must also include the issues surrounding availability, cost (including taxation) and marketing and sponsorship of alcohol.

10. That National health partnership funding models, such as the National Partnership Agreement on Homelessness, need to be encouraged and sustained across lower socio-economic and disadvantaged groups, including the mentally ill, homeless, and people of all ages with drug and alcohol addictions.
11. That funding be increased for translational research and innovation into the causes, treatment and prevention of chronic diseases, particularly with the ageing of the population and conditions such as dementia on the rise.
12. That the Commonwealth Government undertakes a follow-up review of the Applied Economics 2009 report *Returns on investment in public health*<sup>1</sup> in order to provide an updated evaluation on the effectiveness and returns on investment in public health interventions and guide future investments.
13. That the Committee examine alternative financing models such as Social Impact Investing in health prevention programs including for example drug and alcohol addiction and obesity.
14. That the Commonwealth Government adopt the bi-partisan agreed recommendations from the 2013 Senate Community Affairs Committee Report on the social determinants of health and that leadership be shown from the Department of Prime Minister and Cabinet to implement a coordinated whole-of-government approach to social determinants of health and health inequities.

#### **Terms of Reference (e): Improvements in the provision of health services, including Indigenous health and rural health**

15. That the Government put in place national workforce planning strategies that include the appropriate recognition of the role of Aboriginal and Torres Strait Islander health, social workers and community workers; and, appropriate pay, training and resources are made a priority to enable them to do their work effectively.
16. That the Government investigate the development and funding of more regional models for providing continuous preventive, non-acute and acute specialist care to Aboriginal and Torres Strait Islander peoples with chronic disease in comprehensive community-controlled models. This investigation would need to consider management and coordination of the different Commonwealth and State funding streams involved to share the financial responsibilities for this initiative.
17. That the Government investigate a co-contribution of funding with St Vincent's Health Australia and our Northern Territory partner to address chronic kidney disease and the service gaps in renal dialysis for rural and remote Aboriginal and Torres Strait Islander people in the Northern Territory.

#### **Terms of Reference (g): Health workforce planning**

18. That a national health strategic workforce plan be developed through strong Commonwealth national leadership, interagency collaboration and effective industry engagement, with particular reference to:
  - Increasing workforce productivity through the adoption of more innovative work practices.
  - Reviewing existing tertiary education systems so that they better support the delivery of quality training that is responsive and relevant to service needs.

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<sup>1</sup> Applied Economics (2003). Returns on investment in public health. Canberra: Department of Health and Ageing

#### 4. Terms of Reference

- a. **The impact of reduced Commonwealth funding for hospital and other health services provided by state and territory governments, in particular, the impact on elective surgery and emergency department waiting times, hospital bed numbers, other hospital related care and cost shifting**

#### PRINCIPLES

##### St Vincent's Health Australia:

- **acknowledges healthcare reform is both essential and inevitable;**
- **believes responsibility for equity of access to care and health outcomes; funding; and decision making all need to be clarified and simplified if Australia is to successfully reform health care; and,**
- **is advocating for a more robust, mature conversation about future use and access to health care and how it is going to be paid for and by whom.**

##### *Changes to Commonwealth funding arrangements for public hospitals*

In August 2011, all states and territories agreed to the National Health Reform (NHR) package, by signing the National Health Reform Agreement (NHRA), a revised National Health Care Agreement and National Partnership Agreement on Improving Public Hospital Services. Under the agreement, all governments agreed to major reforms to the organisation, funding and delivery of health and aged care services across Australia. The Australian Government at the time, had guaranteed to provide \$16.4 billion of additional funding for public hospitals over the period 2014-2015 and 2019-2020, as well as, increase its contribution to efficient growth funding for hospitals to 45 per cent in 2014-2015, increasing to 50 per cent from 2017-2018. The costs to be met by the Commonwealth would be based on an efficient level of costs, as measured using a "national efficient price" of care determined by an independent body. Several further payments were provided under the *National Partnership on Improving Public Hospital Services* to implement public patient access to elective surgery, emergency department and subacute care services.

The 2014-15 Commonwealth Budget incorporated significant reductions to the above agreed funding arrangements, more specifically:

- From July 2014 to June 2017, NHR funding will be linked to the level of services delivered by public hospitals as provided under the existing NHRA. During this period, each State's entitlement will be directly linked to the growth in public hospital activity provided in that jurisdiction. From 2017-18 the method for allocating funding to states will revert to a system based on population and Consumer Price Index growth. This will see the states receive as much as \$50 billion less for public hospitals until 2024 than under the existing agreement;
- Reward funding to states for Emergency Department and Elective Surgery targets under the National Partnership Agreement on Improving Public Hospital Services would cease from July 2015, representing savings of \$201.1 million over three years. Around \$30.7 million in these payments were made to states and territories in 2013-14; and,
- Funding for the additional sub-acute beds (palliative care, rehabilitation, psychogeriatric care, geriatric evaluation and management and subacute mental care) funded under the NPA would end this financial year.

These changes represent a significant cost shift by the Australian Government to the States and Territories. The narrow tax base of states will make the delivery of these services certainly challenging.

### ***What is the effect on St Vincent's Health Australia public hospitals?***

Each of the St Vincent's Health Australia public hospital facilities has a responsibility to provide health services (supply) for their direct population (demand). There are, however, no constants in this supply and demand correlation, because there is an ever increasing demand on our health (and aged care) services due to a growing and ageing population, new treatments becoming available, increased rates of chronic and preventable disease, and rising health costs. St Vincent's Health Australia of course represents a microcosm of a much wider macro view of the health system, but like all other public hospitals, we are required to operate within the current fragmented governance and accountability framework that exists between the Commonwealth and State, which is in itself, inefficient and in turn, is unable to effectively link patient health outcomes to funding; drive performance; and, reduce health access and inequities.

In short, for St Vincent's Health Australia less funding for our two tertiary public hospitals, St Vincent's Hospital Darlinghurst Sydney and St Vincent's Hospital Fitzroy Melbourne and our four sub-acute facilities: St Joseph's Hospital Auburn and Sacred Heart Service Public in New South Wales; and, St George's Health Service Kew, Caritas Christi Hospice Kew and Fitzroy in Victoria; will ultimately lead to the rationing of services. St Vincent's Health Australia is not in a position to attribute specific impacts of the funding shortfalls by the Commonwealth, particularly as various states have also reduced their annual health budgets at the same time. However, at the clinical level, reductions in funding, by any government for any reason, directly and inevitably result in bed closures, operating theatre shut downs, closing of outpatient clinics and reductions in emergency services. All of this, impacts on patient access to care and treatment and ultimately to the quality of care provided. This scenario will be replicated across all state public hospitals and there will most definitely be a cross section of the community that will not have the same opportunity to maximise their health and well-being due to the difficulty in accessing health care. This will be compounded further by the 2014-15 Commonwealth Budget measures of:

- Patient co-payment introduced for general practice consultations, pathology, diagnostic imaging and emergency departments;
- Medicine co-payments increased and safety net income thresholds increased under the Pharmaceutical Benefit Schedule (PBS); and,
- Indexation of Medicare Benefits and Medicare Levy Surcharge and Private Health Insurance Rebate income thresholds frozen.

The impact of reduced Commonwealth funding for hospitals, therefore, cannot be determined in isolation. A health system requires a strongly linked, aligned and accessible primary and community care service and, private hospital sector, all of which have a strong focus on health outcomes that are delivered at the right place and at the right time. A disincentive to use primary and community care, such as the introduction of co-payments, works against this approach and has the potential to result in increasing rates of hospitalisation, particularly at time when Australia is facing increasing rates of chronic and preventable diseases. Similarly, changes to Federal Government initiatives which currently promote private health insurance participation, could lead to a decline in private health insurance participation and, may in turn, lead to a reduction in demand for private hospital services and an increase in public hospital services.

Of particular concern to St Vincent's Health Australia, is the impact the combined effect of both the reduced Commonwealth funding for hospital and other health services and, the introduction of the co-payments will have on those individuals with the greatest health needs. As a Catholic organisation that has always operated with a particular emphasis on caring for the poor and vulnerable, we need to voice our concern that the measures will create structural barriers to equitable access for the most disadvantaged groups, these include: Aboriginal and Torres Strait Islanders; elderly people; people on low or fixed incomes; people with chronic illnesses; and, people living in rural and remote areas.

St Vincent's Health Australia is of the opinion that whilst the changes in the 2014-15 Commonwealth Budget may have a positive implication for the federal budget, what is required instead, is a national apolitical re-evaluation of how healthcare can be delivered and funded in manner that that accords with the society's preferences and economic requirements. Currently, there is a lack of clarity on the long-term vision and the goals of the health system, and two fundamental hurdles that need to be further debated:

- the first is to move the debate from unsustainable cost rises, to cost effective ways to maximise the health outcomes of the community, particularly health outcomes of national focus, such as rates of diabetes, obesity and cardiovascular disease; and,
- the second hurdle is to create a more cohesive and less fragmented governance and accountability framework through the creation of a single tier of government funder for publicly funded health services.

It is therefore both timely, and appropriate, that the Government has released the Terms of Reference for the Commonwealth's White Paper on the Reform of the Federation. The 2014-15 Commonwealth Budget health measures have heightened the need for all levels of government, the business sector, non-government experts and the community at large, to be extensively consulted about the longer term strategic solution to health care. With limited resources and potentially unlimited demand for health services, there needs to be clarity of responsibility not only for managing funding but also accountability on achieving health outcomes.

Few would argue that due to the separation of Federal and State/Territory funding our current health system is fragmented. The separation of primary care with secondary care and a lack of cohesion between the public and private system has only led to silo structures. Similarly, a population health outcomes model has been debated for well over a decade<sup>2</sup> as a way of addressing the general lack of coordination in planning for health services and, flexibility in integrated delivery across the spectrum from prevention to primary and acute care and community care.<sup>3</sup> This is why, St Vincent's Health Australia is of the opinion that the 2014-15 Commonwealth Budget health measures could potentially further disconnect an already complex, uncoordinated and fragmented system of care that will only: place increased pressure and inefficiencies on the health system; support and strengthen these silo structures; and, continue to place structural access barriers particularly for disadvantaged groups.

The White Paper processes will provide an opportunity to clearly demonstrate that a new more integrated health framework needs to be found, that focuses on addressing duplication in functions, service delivery responsibilities, integrated seamless person centred care, and the end to the cost and blame shifting approach of current Commonwealth and State/Territory governance and funding arrangements.

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<sup>2</sup> Joint Committee of Public Accounts (1995) *The administration of specific purpose payments: a focus on outcomes*, Parliament of the Commonwealth of Australia

<sup>3</sup> Governments Working Together? Assessing Specific Purpose Payment Arrangements Report to the Government of Victoria June 2006, The Allen Consulting Group

## **Recommendations**

- That the Commonwealth develop a long term strategic vision for health and that the goals of the health system should be considered in the context of the White Paper on the Reform of the Federation and the White Paper on the Reform of Australia's Tax System, with a particular focus on:
  - Removing the jurisdictional inefficiencies and structural barriers associated with the divided health care responsibilities of our State and Federal governments in order to:
    - Realign the healthcare portfolio structure with population health management and outcomes-based incentives that is coordinated across the spectrum from prevention to primary and acute care, community care and aged care.
    - Reduce the gradient of health inequity endured by the most socially disadvantaged.
    - Introduce cost effective ways to maximise the health outcomes of the community, particularly those of national focus such as rates of diabetes, obesity and cardiovascular disease and those impacting most directly on poor and vulnerable communities.

### **b. The impact of additional costs on access to affordable healthcare and the sustainability of Medicare**

#### **PRINCIPLES**

##### **St Vincent's Health Australia:**

- **believes health care is a right and should be available on the basis of need not the ability to pay; and,**
- **supports reforms which foster equity, efficiency, transparency and universal access to quality care.**

#### ***Improved Health Outcomes for Australians***

To constructively comment on the impact of additional costs on access to affordable healthcare and the sustainability of Medicare, we need to be cognisant that our health system has over the last 25 years achieved an impressive track-record internationally in addressing public health challenges.

The recent Australian Institute of Health Welfare<sup>4</sup> *Australia's Health 2014* report highlighted Australia's significant improvements in health outcomes over the last quarter of century with notable falls in incidence, hospitalisation and mortality rates across coronary heart disease; strokes; cancers; asthma and chronic obstructive pulmonary disease. In addition, trends in smoking were continuing to fall among adults with a drop of 30.2 percent in the last 50 years<sup>5</sup>, and Australians were consuming less alcohol and abstinence from alcohol was increasing.<sup>6</sup> In 2011-12, more than half (55 per cent) of all Australians aged 15 and over considered themselves to be in 'excellent' or 'very good' health and another 30 per cent said they were in 'good' health.<sup>7</sup>

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<sup>4</sup> AIHW. (2014). *Australia's Health 2014*.

<sup>5</sup> AIHW. (2014). *National Drug Strategy Household Surveys*

<sup>6</sup> AIHW. (2014). *National Drug Strategy Household Surveys*

<sup>7</sup> AIHW. (2014). *Australia's Health 2014*.

Even when comparing ourselves internationally, the 2010 Global Burden of Disease Study<sup>8</sup> confirms that Australia has made significant advances over the last 20 years (to 2010) in reducing years of life lost in areas such as: road injury, where the years of life lost has declined by 40 per cent; heart disease, where the years of life lost has declined by 32 per cent; and stroke, where the years of life lost has declined by 19 per cent. The 2010 study also confirmed that Australia is one of the top performers (among comparison countries – the 15 countries with highest per capita incomes) in reducing the burden of disease (measured in disability-adjusted life years) caused by major depressive disorder (ranked 1st); stroke and osteoarthritis (ranked 2nd); and heart disease and alcohol use disorders (both ranked 3rd). Australia's overall life expectancy of 82.1 years was the 6th highest of the 34 (Organisation of Economic Co-operation and Development) OECD member countries in 2011, and well above the average of 80.2 years.<sup>9</sup>

A key enabler as to why Australia's health outcomes have improved dramatically over the last quarter of century and are some of the highest in the world, is due to Australia's health system which is built on a solid foundation, with Medicare and a strong public healthcare and hospitals sector providing the basis for universal access to quality health care services.

It is equally acknowledged that achieving these significant health improvements has also meant that health spending has increased over the last decade, and this is why, the Government is concerned that unless something is done, health spending is predicted to rise by another three per cent of GDP over the next 20 years from the current GDP level of around 9.1 per cent. It is important to note, however, that our level of expenditure on health care is around the OECD average (9.0 per cent) and for that level of spending we have obtained above average health outcomes (for example life expectancy). Another way of looking at this is to compare Australia's GDP spend of 8.2 per cent in 2001 and that of 2012 of 9.1 per cent, whereas over the same period, our international peers average has increased faster – from 8.8 per cent to 10.3 per cent, and during this time we have managed to achieve life expectancy improvements mirroring other comparable countries.<sup>10</sup> This indicates that our investment in our health system - overall - is delivering good value and is considered to be one of the more efficient health systems in the OECD. In saying this, there are however, signs that indicate our health system is not performing optimally, more specifically there continues to be:

- inequities in the health outcomes between different groups in the community, in particular the continuing poor health status of Indigenous Australians;
- access to quality care by many groups in the community is challenging, including people who are socio-economically disadvantaged and people living in rural areas;
- high rates of preventable illness and diseases and increasing rates of avoidable hospital admissions;
- gaps in the provision of care in specific areas, for example mental health;
- poor coordination of care between health sectors, particularly impacting upon people with chronic and complex illnesses;
- the large number of medical errors and adverse events that occur in the process of delivering care; and,
- workforce shortages across the spectrum of the health system.

It is because of these signs, that St Vincent's Health Australia supports the need for healthcare reform. It is both essential and inevitable, and if not addressed, this will lead to continuing issues around healthcare access and inequity, as well as, funding cuts to other public services, high fees for

<sup>8</sup> Institute for Health Metrics and Evaluation. (2013). *2010 Global Burden of Disease Study*.

<sup>9</sup> OECD (2013) *How Does Australia Compare: OECD Health Data 2013*. In the OECD, only Switzerland, Japan, Italy, Iceland, Spain and France have higher life expectancies

<sup>10</sup> OECD (2014), *National Accounts at a Glance 2014*, OECD Publishing. DOI: 10.1787/na\_glance-2014-en



patients, steep tax increases, growth in government debt, and the ongoing cost and blame shifting approach between the Commonwealth and State/Territories.

St Vincent's Health Australia, however, equally balances this argument with the fact that the health status of the population is an integral component to a strongly performing economy, and is a key factor in shaping the success of the government's economic and social objectives. More importantly, health reform efforts must begin with the principle that decent health care is not a privilege, but a right<sup>11</sup> and a requirement to protect the life and dignity of every person. Since both good health and access to healthcare are deemed basic rights, disparities in either index will provide a measure of inequity and undermine Australia's significant advancements in health outcomes. This is why; we are concerned about the Government's response to sustainability of the healthcare system lies in two areas of the health system that attract a significant portion of the Commonwealth's health expenditure - the Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Schedule (PBS), more specifically:

- Patient co-payment introduced for general practice consultations, pathology, diagnostic imaging and emergency departments.
- Medicine co-payments increased and safety net income thresholds increased under the PBS.

St Vincent's Health Australia considers these proposed measures as regressive, placing the biggest financial burden on low-to-middle income people who already experience the greatest burden of illness and disease. There are numerous studies<sup>12</sup> and surveys<sup>13</sup> that have shown that cost barriers to diagnosis and early treatment will create an environment where individuals already defer medical treatment or filling prescriptions because of financial reasons, which ultimately lead to more preventable and expensive health problems and result in increased future costs. Further, evidence suggests that out-of-pocket costs impact disproportionately on individuals with the greatest health needs including Aboriginal and Torres Strait Islander people, people with chronic illnesses and people living in rural and remote areas.<sup>14</sup>

For St Vincent's Health Australia's two tertiary acute public hospitals, St Vincent's Hospital Darlinghurst Sydney and St Vincent's Hospital Fitzroy Melbourne, the co-payments provides an additional burden because there is a risk that a co-payment on primary health care services will result in patients seeking similar treatments in our public hospital emergency departments to avoid the co-payment. This contention is given some weight by the ABS Patient Experiences survey, which reveals that social economically disadvantaged individuals are more likely to visit the emergency department compared to those who are better off (15.6 per cent compared with 11.3 per cent).<sup>15</sup>

It is also important to note that our hospital emergency departments already provide a significant level of care to patients who could be considered General Practitioner (GP) type patients. Some of these

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<sup>11</sup> Rights to healthcare are outlined in the *Australian Charter of Healthcare Rights*. In July 2008, Australian Health Ministers endorsed the charter for use across the country. It can be accessed at: <http://www.safetyandquality.gov.au/national-priorities/charter-of-healthcare-rights/>

<sup>12</sup> Cathy Schoen and Robin Osborn *The Commonwealth Fund 2008 International Health Policy Survey in Eight Countries* The Commonwealth Fund November 2008  
David Squires *Multinational Comparisons of Health Systems Data, 2013* Commonwealth Fund 2013

Schoen C, Osborn R, Squires D, et al. Access, affordability, and insurance complexity are often worse in the United States compared to ten other countries. *Health Affairs*. 2013;doi: 10.1377/hlthaff.2013.0879

Kil A, Houlberth K. How does co-payment for health care services affect demand, health and redistribution? A systematic review of the empirical evidence from 1990 to 2011. *European Journal of Health Economics*. 2013;doi: 10.1007/s10198-013-0526-8

Hynd A, Roughhead EE, Preen DB, et al. The impact of co-payment increases on dispensings of government-subsidised medicines in Australia. *Pharmacoepidemiology and Drug Safety*. 2008;17(11):1091-9.

Sinnott SJ, Buckley C, O'Riordan D, et al. The effect of co-payments for prescriptions on adherence to prescription medicines in publicly insured populations; a systematic review and meta-analysis. *PLoS One*. 2013;8(5):e64914.

Doggett J. Empty Pockets: Why co-payments are not the solution. *Consumers Health Forum*. Manuka: 2014.

<sup>13</sup> Australian Bureau of Statistics *4839.0 - Patient Experiences in Australia: Summary of Findings, 2012-13*

<sup>14</sup> McRae I, Yen L, Jeon YH, et al. Multimorbidity is associated with higher out-of-pocket spending: a study of older Australians with multiple chronic conditions. *Australian Journal of Primary Health*. 2013;19(2):144-9.

Kemp A, Glover J, Preen DB, et al. From the city to the bush: increases in patient co-payments for medicines have impacted on medicine use across Australia. *Australian Health Review*. 2013;37(1):4-10.

Jan S, Essue BM, Leeder SR. Falling through the cracks: the hidden economic burden of chronic illness and disability on Australian households. *Medical Journal of Australia*. 2012;196(1):29-31.

<sup>15</sup> ABS Patient Experiences in Australia: Summary of Findings, 2012-13 4839.0

services are legitimate emergency department attendances, but others are as a result of patients seeking alternatives to primary care due to unaffordability and unavailability, this is particularly the case for our chronically homeless individuals and people suffering from mental health issues. As there is no standard methodology for determining the true proportion of GP type patients in emergency departments, there is limited capacity to accurately predict the impact of an MBS co-payment on presentations to emergency departments.<sup>16</sup> As part of the reform initiatives, it is recommended that a study be taken to identify why health consumers preferentially choose emergency departments for conditions that could be managed in the primary care setting to assist with the development of policy to encourage the correct use of primary care and emergency services. In addition, there is a need to fully interrogate all available data to understand the full range of impacts of current out-of-pocket expenditure on consumer behaviour before introducing these broad changes.

St Vincent's Health Australia therefore cautions against focusing on seeking to reduce expenditure on the MBS and the PBS in isolation, and recommends that a robust debate be undertaken to understand the impact of these reforms, particularly on the most vulnerable, before implementation, to reduce the risk of unintended consequences and perverse outcomes.

In this regard, St Vincent's Health Australia would like to draw the Senate Select Committee's attention to the recently released Community Affairs References Committee report into out of pocket costs in Australian healthcare. The committee received 106 submissions from a diverse range of individuals and organisations and concluded with the following recommendations, which St Vincent's Health Australia supports:

### ***Recommendations***

- That the Senate Select Committee examines the recently released Community Affairs References Committee report into out of pocket costs in Australian healthcare and adopt the following recommendations, which St Vincent's Health Australia supports:
  - That the Government should not proceed with further co-payments.
  - That the Government undertake a comprehensive review of the impact of existing co-payments on individuals' access to health services and health outcomes. The review should pay particular attention to the impact on the most vulnerable groups in the community.
  - That the Government review the impact and effectiveness of existing safety nets to ensure that current safeguards provide adequate protection to the most vulnerable in the community.
  - That the Government review the Pharmaceutical Benefits Scheme to identify areas where efficiencies can be gained, with particular reference to the following areas:
    - current procurement and pricing structures, with particular reference to examining benchmarking as a mechanism to explore the extent to which savings could be achieved;
    - effective monitoring and review of GP prescribing practices to ensure dispensed medications are cost effective and evidence based; and

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<sup>16</sup> For example, the Australasian Triage Scale (ATS) is often used to associate GP type patients with ATS categories 4 and 5, however, the ATS is an urgency scale not a complexity scale and so does not allow for the accurate categorisation of patients who could have sought treatments in a primary context.

- evaluation of the prevalence of patient non-adherence to prescribed medication, with particular reference to identifying reasons for non-adherence.
- That the Government review existing models for funding and delivery of primary healthcare with a view to identifying opportunities for improved service delivery and health outcomes.
- Oppose the introduction of:
  - Patient co-payment introduced for general practice consultations, pathology, diagnostic imaging and emergency departments, and
  - Medicine co-payments increased and safety net income thresholds increased under the PBS

on the basis that St Vincent's Health Australia considers such measures as regressive, placing the biggest financial burden on low income people who already experience the greatest burden of illness and disease.
- That an ongoing monitoring program be put in place to prevent adverse consequences in health outcomes being experienced by socioeconomically disadvantaged Australians. Such a monitoring program should be underpinned by a commitment to remedy any adverse consequences that might become apparent.

### ***Emergency department co-payments***

The introduction of a co-payment in public hospital emergency departments has been identified by the Government as a way to ensure that additional co-payments on primary health care services do not redirect patients to emergency departments. There are a number of inherent challenges in this measure:

- The current system for categorising patients in emergency departments does not include a definition of who would be regarded as a GP type presentation.<sup>17</sup> Even where a patient is attended by key markers (low acuity, not being admitted, has not previously been seen by a GP), it has been noted that these markers represent individuals with the greatest health needs including: Aboriginal and Torres Strait Islander people, people with chronic illnesses, chronically homeless individuals (to mention but a few). Any fee in emergency departments that discouraged attendance for the poor and vulnerable who face potentially life threatening conditions, would be extremely unfortunate outcome for public health care in Australia, and would go against our values as a Catholic organisation of caring for the poor and vulnerable.
- The introduction of an emergency department co-payment is not a simple matter. Co-payment revenue collection in emergency departments will require additional staff and impose additional costs that may well be greater than the revenue collected.
- The potential transfer of patients to hospital care through avoiding or delaying primary care due to cost factors may mean that the revenue raised through co-payments or savings due to reduced demand, will be more than offset by the costs of hospitalisation and the associated economic costs of chronic illness such as loss of earnings, disability pensions.
- A sustainable public health system relies on accessing the right service, at the right time and the right place, this means that patients should be directed to the most effective and inexpensive care option and not forced to the more expensive acute public hospital care because of financial barriers in accessing primary care. There is significant flow on costs when a patient presents to

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<sup>17</sup> For example, the Australasian Triage Scale (ATS) is often used to associate GP type patients with ATS categories 4 and 5, however, the ATS is an urgency scale not a complexity scale and so does not allow for the accurate categorisation of patients who could have sought treatments in a primary context.

an emergency department with associated costs for imaging, testing, diagnosis and follow up, all of which would be borne by the state governments.

### **Recommendations**

- That a study is taken to identify why health consumers preferentially choose emergency departments for conditions that could be managed in the primary care setting to assist with the development of policy to encourage the correct use of primary care and emergency services. Such a study would need to be conducted periodically to gauge any consumer changes based on the introduction of a co-payment on primary health care services.
- The study should have a particular focus on patients seeking alternatives to primary care due to unaffordability and unavailability, this being particularly significant for our chronically homeless individuals, people with drug and alcohol addictions and people suffering from mental health issues.
- That a study is conducted to establish the cost benefit in implementing and delivering emergency department co-payments and to investigate the flow on costs to the public hospital sector; and, examine what effect co-payments may have on individuals from lower socio-economic groups who have lower life-expectancy and overall poorer health.

### **c. The impact of reduced Commonwealth funding for health promotion, prevention and early intervention**

#### **PRINCIPLES**

**St Vincent's Health Australia believes:**

- **that as a nation we have a responsibility to ensure equitable health outcomes to all citizens;**
- **evidenced based promotion and prevention programs and early intervention have the potential to significantly reduce disease and disability and reduce the growing economic burden on the health care system;**
- **there is clear evidence that there is a social gradient of health and the introduction of any new co-payments will only further exacerbate healthcare access to prevention programs and early intervention and ultimately lead to greater long-term financial and health costs to the Australian community;**
- **addressing the social determinants of health and reducing inequities will not only improve population health and well-being, but it will also make Australia fairer, more inclusive and sustainable; and,**
- **a whole-of-government approach to address both risk and environmental factors that is driving preventable chronic disease health care costs is paramount.**

Australia and the world are facing a growing epidemic of chronic disease. This increasing prevalence of chronic disease places extended demands on health care services and upward pressure on health care financing. However, we also know what causes much of chronic disease and this means that we can prevent or predict, detect and diagnose earlier and so intervene earlier.

For Australia, approximately 40 per cent of current potentially preventable hospitalisations are for chronic conditions associated with alcohol, tobacco and obesity.<sup>18</sup> With an anticipated 80 per cent increase in health care expenditure (\$12.1 billion in 2002/03 to \$21.8 billion in 2017/18) for just three chronic conditions: cancer, cardiovascular disease and diabetes<sup>19</sup>, it is clear there is a role for governments to design incentives to change individual, industry and provider behaviour that will in turn promote health and focus competition on outcomes. The World Health Organisation goes as far as defining the role of governments as one of stewardship, beyond just the financing and delivery of health care systems.

Based on a Catholic social teaching principle of the common good, St Vincent's Health Australia firmly believes that as our knowledge of harmful effects of particular behaviours becomes ever clearer from a scientific perspective, it is appropriate for Governments, churches and non-government civil society organisations to play a strong role in encouraging people to reduce behaviours that are harmful to health. This is why as an organisation, we are committed to providing and partnering with other organisations in a wide array of health promotion, prevention and early intervention programs and research because:

- this is what communities want and expect from their health system;
- we believe that good health is an important priority to enable everyone to achieve their full potential, particularly the vulnerable and disadvantaged who without these interventions would continue to experience worse outcomes than those in higher socio-economic areas: 'If the populations of the most disadvantaged areas had the same death rate as those living in the most socio-economically advantaged areas then a half to two-thirds of premature deaths would be prevented'<sup>20</sup>;
- the person centre care model that St Vincent's Health Australia has adopted is about treating the whole individual and their circumstance, rather than just a condition or undertaking a procedure;
- economically it makes sense - it enables potentially preventable admissions to hospitals;
- our commitment to providing excellent aged care services is also about raising awareness on positive ageing and to encourage people to adopt preventive health strategies especially in relation to chronic diseases such as dementia, arthritis, macular degeneration and diabetes that affect so many Australians as they grow older;
- the causes, treatment and prevention of chronic diseases, particularly with the ageing of the population and conditions such as dementia on the rise, demands that resources be committed to translational research and innovation which we feel we can contribute in partnership with our affiliated institutes and universities.

At the same time, St Vincent's Health Australia acknowledges that there is a fine line in balancing individual rights and that of an interventionist approach by Government, and more importantly, that this is a deeply complex issue because individual health and risk behaviours are influenced by families, communities, schools and workplaces; by beliefs and understandings; by industry and market forces; by income and social trends (health determinants including social determinants).

St Vincent's Health Australia, however, is of the opinion that the impact of reduced Commonwealth funding for health promotion, prevention and early intervention will be detrimental to our society. A healthy economic future for Australia is intimately linked to the future health and wellbeing of our population and part of that strategy to achieve a healthy, productive future must include an investment in preventive health policies and programs. This can be clearly supported by the recently published

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<sup>18</sup> AIHW (2013). Australian hospital statistics 2011–12. Health services series no. 50. Cat. no. HSE 134. Canberra: AIHW).

<sup>19</sup> (Vos T, Goss J, Begg S and Mann S (2007). Projection of health care expenditure by disease: a case study from Australia. See <http://www.un.org/esa/policy/wess/wess2007files/backgroundpapers/australia.pdf>.)

<sup>20</sup> CHA–NATSEM report on health inequalities

Australian Institute of Health and Welfare data that shows the rate of decline in mortality from cardiovascular disease, still Australia's biggest killer, is slowing, especially among cohorts under 55 years of age.<sup>21</sup> The more than 60 per cent reduction in cardiovascular mortality since the mid-1960s is one of Australia's great prevention success stories and demonstrates that policies and programs aimed at behaviour change, measured across a population, take many years through which efforts must be sustained and responsive. So, in terms of future productivity and health care costs, this slowing of the decline in mortality from cardiovascular disease (which is consistent with changes in risk factors including increasing rates of diabetes) should be a major concern. In addition, the recent evidence showing the slowing in the rate of increase in childhood obesity<sup>22</sup> and reductions in smoking rates among Indigenous populations<sup>23</sup> all indicate reasons for more, and not less, investment in health promotion, prevention and early intervention of chronic disease.

Finally, it is important to note that the evidence that prevention programs are effective and yield substantial dividends to the community were confirmed more than ten years ago when the Howard Government commissioned the most comprehensive review of the value of Australian preventive health efforts. Conducted by Applied Economics the 2009 report *Returns on investment in public health*<sup>24</sup> examines the value of Australia's investment in five major prevention programs: tobacco control, coronary heart disease; HIV/AIDS; vaccination against measles; and road trauma and concluded that these programs resulted in net savings to government by reducing demand for health care services. The report states that "from a societal perspective, the return of prevention programs to the community is the important outcome rather than the narrower measure of the financial return to government"

### **Recommendations**

- That the Commonwealth Government adopt as a fundamental principle underpinning its health funding strategies that evidence-based long-term health promotion, prevention and early intervention programs have the greatest potential to significantly reduce disease and disability and thereby reduce the economic burden on the health care system.
- That long-term, bipartisan funding commitments be made for health promotion, prevention and early intervention and that all such programs have a specific focus on the poor and vulnerable and marginalised communities who experience worse health outcomes, worse quality of life, and lower life expectancy than those in higher socio-economic groups.
- That funding be increased for translational research and innovation into the causes, treatment and prevention of chronic diseases, particularly with the ageing of the population and conditions such as dementia on the rise.
- That the Commonwealth Government undertakes a follow-up review of the Applied Economics 2009 report *Returns on investment in public health* in order to provide an updated evaluation on the effectiveness and returns on investment in public health interventions and guide future investments.
- That the Committee examine alternative financing models such as Social Impact Investing in health prevention programs including for example drug and alcohol addiction and obesity.

<sup>21</sup> Australian Institute of Health and Welfare. Trends in coronary heart disease mortality: age groups and populations. Canberra: AIHW, 2014. (AIHW Cat. No. CVD 67; Cardiovascular Disease Series No. 38.)<http://www.aihw.gov.au/publication-detail/?id=60129547046>.

<sup>22</sup> Olds T, Maher C, Zumin S, et al. Evidence that the prevalence of childhood overweight is plateauing: data from nine countries. *Int J PediatrObesity* 2011; 6: 342-360

<sup>23</sup> Australian Bureau of Statistics. The Australian Aboriginal and Torres Strait Islander Health Survey 2012–13. Tobacco Smoking. Canberra: ABS, 2013.<http://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/39E15DC7E770A144CA257C2F00145A66?opendocument>

<sup>24</sup> Applied Economics (2003). Returns on investment in public health. Canberra: Department of Health and Ageing

### ***The indirect adverse effect of co-payments on health prevention***

St Vincent's Health Australia believes that the \$7 co-payment for general practice and pathology services that will be felt in primary care will have a significant indirect adverse effect on prevention, especially of chronic diseases. There are a number of international studies that have found that the effects of medical service pricing on the behaviour of patients required to pay a co-payment reduced their attendance for preventive activities.<sup>25 26 27</sup> For patients with chronic diseases, each general practice visit will incur a co-payment of at least \$14 (consultation plus pathology tests) and this does include the additional co-payment for prescription medications. The effects of these co-payments on preventive behaviour are greatest among those who can least afford the additional costs (such as older people, people on low incomes and people with chronic illnesses) and are often at a health disadvantage.<sup>28</sup> Recent Australian data collected by the Commonwealth Fund<sup>29</sup> analysis into the performance of healthcare systems across eleven developed countries, found Australia ranked ninth worst in 'Cost-related access problems.'<sup>30</sup> In addition, the Australian Bureau of Statistics (ABS) found that in 2010-11, approximately 8 per cent of Australians (aged >15 years) reported that they had delayed seeing, or did not go to see a General Practitioner (GP), because of cost<sup>31</sup>. In addition, approximately 15 per cent of people who had seen a GP in that period reported that they felt they had waited too long for an appointment.<sup>32</sup>

As a nation, it is imperative that we redress health disadvantage across the social gradient and this is why we are concerned about the trend towards the use of individual co-payments as a mechanism for the funding of health. Once again, we would like to draw the Senate Select Committee's attention to the recently released Community Affairs References Committee report into out of pocket costs in Australian healthcare and the recommendations, which St Vincent's Health Australia supports.

### ***Health in All Policies - Social Determinants of Health***

Advocating for the health and wellbeing of a community requires that health promotion, prevention and early intervention programs/strategies become everyone's business not just that of health. This is because the majority of chronic conditions are preventable, and more importantly, are closely linked with living conditions or the determinants of health which tend to be influenced by policies outside the health sector. It is acknowledged that all three levels of government share the preventive health responsibility in Australia, however, the case for national leadership at a Commonwealth level is imperative on both efficiency and effectiveness grounds; otherwise the benefits of preventive health both in terms of improving the health of the population; including their ability to contribute to economic productivity; as well as, the positive long-term financial impact on publicly-funded health care systems is hindered.

This is why St Vincent's Health Australia believes that in order to improve societal health and wellbeing, and address the growing epidemic and escalating costs of chronic disease to the community, Government action on the social determinants of health and health inequalities needs to be addressed as they undermine our social and economic well-being. Evidence shows that the higher your income or level of education in Australia, the better your health will tend to be. People in the most disadvantaged social groups are also far more likely than those in the higher socioeconomic groups to have long-term chronic, physical or mental health problems. They also are less able to

<sup>25</sup> Keeler EB. Effects of cost sharing on use of medical services and health. *J Med Pract Manage*1992; 8: 317-321

<sup>26</sup> Kil A, Houbert K. How does copayment for health care services affect demand, health and redistribution? A systematic review of the empirical evidence from 1990 to 2011. *Eur J Health Econ* 2013; 29 Aug [Epub ahead of print]. doi: 10.1007/s10198-013-0526-8

<sup>27</sup> Goodwin SM, Anderson GF. Effect of cost-sharing reductions on preventive services use among Medicare fee-for-service beneficiaries. *Medicare Medicaid Res Rev* 2012; 2: 002.01.a03. doi: 10.5600/mmrr.002.01.a03

<sup>28</sup> Cesare MD, Khang YH, Asaria P, et al. Inequalities in non-communicable diseases and effective responses. *Lancet* 2013; 381: 585-597

<sup>29</sup> David Squires Multinational Comparisons of Health Systems Data, 2013 Commonwealth Fund 2013

<sup>30</sup> The Commonwealth Fund. 2014. *Mirror, Mirror on the Wall: How the Performance of the U.S. Health Care System Compares Internationally*.

<sup>31</sup> Australian Bureau of Statistics. General practitioners, medical specialists and dental professionals (Chapter 4). *Patient Experiences in Australia: Summary of Findings, 2010-11*. ABS, 2011.

<sup>32</sup> Australian Institute of Health and Welfare 2014. *Australia's health 2014*. Australia's health series no. 14. Cat. no. AUS 178. Canberra: AIHW

complete an education or maintain a job to retirement, and are more likely to die at a younger age.<sup>33</sup> The health disadvantage across the social gradient is ever clearer when we examine these economic, social and cultural factors and support the findings from the World Health Organisation's (WHOS) report, *Closing the gap in a generation: Health equity through action on the social determinants of health*.<sup>34</sup>

An analysis<sup>35</sup> to demonstrate what the gains would be, if the recommendations from the WHO report were adopted in Australia found that: the lowest 20 per cent of income earners suffer twice the amount of chronic illness than the highest 20 per cent; 500,000 people could avoid chronic illness; \$2.3 billion in annual hospital costs could be saved; and, the annual number of taxpayer-funded Pharmaceutical Benefits Scheme prescriptions could be cut by 5.3 million. It also revealed avoidable chronic illness costs the Federal Government \$4 billion each year in welfare payments and the national economy \$8 billion in lost earnings.

The health, social and economic impact is significant, and this is why St Vincent's Health Australia is a member of the Social Determinants of Health Alliance (SDOHA) a collaboration of Australian organisations from the areas of health, social services, and public policy, which believes it is essential that government heed the findings and recommendations of the WHO's Commission on the Social Determinants of Health report if we are to address the causes of health inequity in Australia. Such an approach would see a focus on "health in all policies" across all policy domains such as agriculture, education, the environment, fiscal policies, housing and transport making Australia fairer, more inclusive and sustainable. The recent 2013 inquiry and report by the Senate Community Affairs Committee on the social determinants of health and Australia's domestic response to the World Health Organization's (WHO) commission report, *Closing the gap within a generation*, concluded with bipartisan support that the Government adopt the WHO Report and commit to addressing the social determinants of health relevant to the Australian context. St Vincent's Health Australia along with the other members of the SDOHA applauded this finding, and now is urging that leadership and strategic direction at a Commonwealth level be established to implement a coordinated whole-of-government approach to social determinants of health and health inequities.

### **Recommendations**

- That the Commonwealth Government adopt the bi-partisan agreed recommendations from the 2013 Senate Community Affairs Committee Report on the social determinants of health and that leadership be shown from the Department of Prime Minister and Cabinet to implement a coordinated whole-of-government approach to social determinants of health and health inequities.

### **Case Study - St Vincent's Health Australia - Alcohol related harm and violence**

A clear example where "health in all policies" has been applied, is in the area of alcohol related harm and violence when the then NSW Premier, the Hon. Barry O'Farrell MP, announced the creation of a new entertainment 'precinct' for which special alcohol licensing conditions would apply, and the introduction of a NSW wide ban on takeaway alcohol sales after 10pm. The measures have drawn together cross collaboration and commitment by government agencies such as: health; police; justice; ambulance; local government; and, industry stakeholders, all of whom are focused on identifying the right balance of policy measures going forward.

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<sup>33</sup> Commission on the Social Determinants of Health (2008) *Closing the gap in a generation: Health equity through action on the social determinants of health*. Geneva: World Health Organisation

<sup>34</sup> Commission on the Social Determinants of Health (2008) *Closing the gap in a generation: Health equity through action on the social determinants of health*. Geneva: World Health Organisation

<sup>35</sup> National Centre for Social and Economic Modelling *The Cost of Inaction on the Social Determinants of Health Catholic Health Australia* August 2012. Commissioned by Catholic Health Australia



As an organisation, we were one of the first to voice our support to the NSW government, because our key NSW public hospital, St Vincent's Hospital Sydney, bears the brunt of the harmful supply and consumption of alcohol with increased pressure and costs on our emergency department and hospital services. We also supported the measures because we strongly believe that:

- alcohol related harm and violence can be prevented and its impact reduced;
- the deaths, injuries and associated trauma for individuals and their loved ones, that are the most devastating impacts of alcohol related violence, are contrary to human dignity and our community's health and well-being; and,
- the annual costs to society in the health care sector, as well as, other government agencies such as: police; family and community services; justice and correction services are increasingly unsustainable and unacceptable, with a direct societal cost of approximately \$14,352b (2010 dollars) which outweighs the revenue generated from alcohol taxation by a ratio of 2:1.<sup>36</sup>

The positive news is that the recent NSW measures have seen noticeable reductions in alcohol related presentations to our emergency department and hospital services, including fewer serious injuries. This is a clear example of where government prevention and intervention has been effective and can yield substantial dividends to the community.

What is needed now, however, is continued commitment and real action by the Commonwealth Government because our communities are no longer willing to pay the huge financial and devastating human and emotional costs associated with alcohol harm and violence. The costs to governments, communities, employers, individuals and productivity are an increasing and crippling financial burden. It is therefore timely, to call on the Federal Government to convene a National Summit to discuss and assess the evidence and develop effective national "health in all policies" solutions to the epidemic of alcohol misuse and harms afflicting our communities. A National Summit will bring together representatives of all Australian governments, local councils, community leaders, medical and health experts, police, teachers, industry, parent groups, families of victims, and other stakeholders to develop practical nationally-consistent solutions and policies to tackle the harms of excess alcohol use that affect many Australians. There are solutions at hand and an international framework ready to adopt, of which St Vincent's Health Australia believes they can play a crucial participatory role through evidence based research and education, to demonstrate that the alcohol supply and demand variables need to be managed appropriately.

### ***Recommendations***

- That the Commonwealth Government urgently address the unsustainable economic and social cost burden caused by the misuse of alcohol, together with very significant community concern about alcohol-fuelled violence, by convening a National Alcohol Summit to develop a broader national policy framework on how to improve the health, social and economic outcomes for Australians by reducing the harmful effects of alcohol in society. The Summit agenda must also include the issues surrounding availability, cost (including taxation) and marketing and sponsorship of alcohol.

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<sup>36</sup> Source: Trends & issues in crime and criminal justice no. 454 Matthew Manning, Christine Smith and Paul Mazerolle ISSN 1836-2206 Canberra: Australian Institute of Criminology, April 2013

## **Case Study - St Vincent's Health Australia Preventive and Early Interventional Care Model in Homeless Health**

St Vincent's Health Australia recognises that as a Catholic health and aged care ministry we have a moral obligation to care for all in need, especially those who are vulnerable, and to place our resources in the service of the good of the whole community. We have a further obligation to look at the world from the perspective of those who are excluded, and to work with them to restore their full participation. When we return those who are vulnerable to full participation in society, we strengthen the whole community. In fact we cannot be a whole and healing community when some people are denied full participation.

As an organisation, however, the problem we face daily is the fact, and of which is supported by evidence,<sup>37 38</sup> that people who are poor and vulnerable tend to seek assistance at hospital emergency departments in a crisis rather than accessing early care through a local doctor. This means that people are often more unwell and more socially isolated by the time they encounter care than might otherwise be the case, leading to complex care needs and associated costs. This is why we are constantly looking at alternative collaborative models of care with General Practitioners, Non-Government Organisations and local government agencies that focus efforts on improving health outcomes for the poor and vulnerable prior to the point of crisis. The aim of these collaborative partnerships and/or new models is to broaden the traditional focus on acute care, strengthen health promotion capacity within communities, and restrain the health expenditure that occurs in hospital services which accounts for around 40 per cent of health expenditure in Australia.

St Vincent's Health Australia has put in place a large number of programs and services that provide prevention and early intervention and move towards accountable care models that aim to deliver: proactive preventative health care; access to the right care and a better more effective patient experience; lower cost; and, better care and incentive alignment to outcomes. A case in point is the St Vincent's Hospital Network Sydney (SVHNS), Homeless Health Framework where in partnership with a number of external organisations (community based agencies and other health and welfare providers) we are working in unison to provide one integrated and cohesive model of care. Located in an area characterised by a population with Australia's highest concentration of homelessness, SVHNS provides community outreach in streets, parks and general community settings. The traditional design of health services tends to support a fragmented approach to care, with limited integration between specialities, however, homeless individuals frequently present with a range of co-occurring health conditions along with housing and other psychosocial issues, all of which call for a holistic integrated approach. To address this, SVHNS have implemented a wide range of services that deliver cohesive, multi-speciality care-co-ordination in a range of outreach and campus-based services designed to meet each individual's health needs and reduce readmission into an acute care setting. These initiatives have worked because the National Partnership Agreement on Homelessness has channelled and targeted funding appropriately to specified outcomes, which in turn, has enabled partnerships to occur across agencies and other organisations. St Vincent's Health Australia would welcome an opportunity to discuss with the Senate Select Committee the range of services we provide that target the poor and vulnerable such as: alcohol and drugs; mental health; Aboriginal health; asylum seekers in community; to mention but a few, and demonstrate that national partnership funding models need to be encouraged and sustained across these population groups. Never has this been more urgent than now, because as an organisation we are experiencing: a rise in the demand for services by these population cohorts; and, a widening of gaps in both health outcomes and ability to access health care. In this respect we again caution, that the impact of reduced funding by the

<sup>37</sup> 2014 Productivity Commission Report on Government Services 2014: Volume E: Health p.37 accessible via [http://www.pc.gov.au/\\_data/assets/pdf\\_file/0019/132346/rogs-2014-volumee-health.pdf](http://www.pc.gov.au/_data/assets/pdf_file/0019/132346/rogs-2014-volumee-health.pdf)

<sup>38</sup> As reported in 2014 Closing the Gap: Prime Minister's Report p.8 accessible at [http://www.dpvc.gov.au/publications/docs/closing\\_the\\_gap\\_2014.pdf](http://www.dpvc.gov.au/publications/docs/closing_the_gap_2014.pdf)

Commonwealth and the additional costs on access to affordable healthcare, will ultimately mean that targeted services to the poor and vulnerable will be under immense strain to remain sustainable.

### ***Recommendations***

- That National health partnership funding models, such as the National Partnership Agreement on Homelessness, need to be encouraged and sustained across lower socio-economic and disadvantaged groups, including the mentally ill, homeless and people of all ages with drug and alcohol addictions.

### ***Case Study - St Vincent's Health Australia's Aikenhead Centre for Medical Discovery***

St Vincent's Health Australia has a vision to establish Australia's first biomedical engineering research and education hub in Victoria, the Aikenhead Centre for Medical Discovery (ACMD). Bringing together research and training from leading hospitals, universities and medical research institutes in a purpose built centre, with necessary Victorian Government funding support, the ACMD will drive medical innovation to help stem the tide of rising health costs, will generate new jobs in advanced manufacturing and enable Australians to live longer, more productive lives. In a world first, ACMD will integrate graduate and post-graduate programs from medicine, engineering and science into the new facility. The combination of graduates with advanced skills, the best international minds, and a diverse group of founding partner organisations will address the nation's health priorities and create manufacturing jobs in Victoria.

St Vincent's Health Australia and its ACMD partner organisations are determined to demonstrate as per the international evidence, that hospitals and healthcare facilities that do research deliver higher quality care, have better patient outcomes and are more efficient. We would welcome an opportunity to discuss this important innovative investment with the Senate Select Committee, and demonstrate that advances in the biotechnology will lead to better health outcomes for patients and in turn, reduce the health expenditure dollar.

#### **d. The interaction between elements of the health system, including between aged care and health care**

### **PRINCIPLES**

**St Vincent's Health Australia believes:**

- **The interaction between the health care system and aged care cannot continue as is without failing to meet community expectations and compromising the quality and spectrum of care provided to older Australians; and,**
- **A wellness approach, comprehensive assessment and flexible integrated aged care models that restore or maintain people's independence for longer, will enable the most effective use of Government funding; and increase people's wellbeing and dignity.**

Older people are enjoying more years of healthy, active living than any generation before them. Many continue to work, help their families and friends, volunteer their time and pursue their personal interests. However, a growing and significant proportion of older people are also living with complex health needs and this is particularly highlighted by the projected rise in the number of people diagnosed with dementia from 322,000 people in 2013 to 400,000 by 2020 and around 900,000 by 2050.<sup>39</sup>

One of the key challenges older people with health needs experience, alongside with their carers and family, is the complex, multiple, disconnected and often duplicative interactions with the health system and aged care system. This lack of connectivity has been due to the different roles, responsibilities and funding models between health and social service delivery across public, private and non-government sectors (community-based aged care, acute healthcare, primary healthcare, and residential aged care). For this reason, care is often provided in parallel by different healthcare professionals and different services; with little information, coordination or linkages between them; and, each episode is not connected to previous or future episodes of care.

There have been significant efforts to by all levels of government, including the private and non-government sectors to work in collaboration and coordination with each other to integrate the health and aged care system, and the process is continually evolving with the Commonwealth, State and Territory Governments working through the national reforms of the health and aged care systems. It is important that during this reform process potential opportunities can be leveraged these include, but are not limited to:

- Primary Health Networks working together with Local Health Districts to help drive improvements, particularly in the way in which health and aged care services can work together and facilitate shared planning and integrated service models.
- Consumer-directed care in the community aged care sector that will encourage more patient and consumer-centred models of care to be considered.
- Activity based funding for the hospital sector that will lead to the consideration of the most efficient and effective service delivery models, and who within the system is best to deliver these.

Equally the reforms present challenges:

- The ways in which some services are delivered, funded and resourced will change over time meaning that flexibility will need to be built into service models.

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<sup>39</sup> Department of Health (nd). Dementia . Accessed < <http://www.health.gov.au/dementia>>

- With the introduction of consumer-centred care in community aged care, care plans will be developed for the client, building on care plans that may already exist within the primary care and the acute sectors.
- The Personally Controlled Electronic Health Record presents a key enabler to better information sharing and self-management but will take some time before it can enable a shared care plan.

As an aged and health care service provider, St Vincent's Health Australia is keen to maximise these opportunities and manage the challenges that lie ahead by collaborating with government bodies and other stakeholders, on how best to begin to target limited resources in a coordinated way, share budgets (if possible) and reduce duplication to improve outcomes for older people. A clear example of this is the greenfield development of our new hospital and aged care services precinct in Werribee Victoria, which is anticipated to be completed in 2017, and will offer an integrated care model across the spectrum for the older person living in Werribee and surrounding suburbs.

St Vincent's Private Hospital Werribee (seven operating theatres, three delivery suites, a day procedure centre and 112 beds - 80 medical/surgical/rehabilitation and 32 maternity) will be collocated with a standalone 80 bed Aged Care Residence that will consist of dementia care and high care ageing in place and respite care, as well as, a Wellness Centre, Rehabilitation Clinic and Gymnasium, Chapel and co-located specialist and general practitioner clinics. The co-location of these services will deliver improved access and integrated care across the primary, acute, sub-acute, aged care and community spectrum. The aim is to both support older people living in the Werribee community to access all these services at one location, as well as, provide integrated care to our aged care facility residents. St Vincent's Health Australia is currently working closely with a number of government and non-government stakeholders to put in place the right multidisciplinary leadership, mechanisms and incentives to facilitate this. Our goal is to develop a shared vision for integrated aged health services within the Werribee community by adopting a person-centred approach to the provision of care and services.

## **e. Improvements in the provision of health services, including Indigenous health and rural health**

### **PRINCIPLES**

**St Vincent's Health Australia believes:**

- **working in partnership is the key to realise equity in health care for Aboriginal and Torres Strait Islander people.**

The inequities in health outcomes experienced by Aboriginal and Torres Strait Islander people are well publicised. St Vincent's Health Australia is proud to work in partnership with many Indigenous communities to change this and help these communities to further develop their own expertise and skills in health care delivery and disease prevention. Guided by the *St Vincent's Health Australia Reconciliation Action Plan*, we have been proactively initiating specific programs that are working to foster and support equity and access to healthcare in Aboriginal and Torres Strait Islander communities.

One of our key focus areas has been to ensure we deliver appropriate person centred care services to Aboriginal and Torres Strait Islander people by establishing Aboriginal Health Liaison Officer (AHLO) and Aboriginal Health Network Coordinator (AHNC) roles at St Vincent's public hospitals in Melbourne and Sydney. Staffed by Indigenous people, these individuals provide support to

Indigenous inpatients in hospital and coordinate care with local providers to ensure that patients are linked in to ongoing support on discharge. AHLOs and AHNCs play a significant role in linking mainstream health services like St Vincent's with Indigenous health care providers and they are also a vital resource of expertise providing cultural awareness training and advice to their fellow health care colleagues, ensuring that care provided to Indigenous people is delivered in a manner that is culturally sensitive and safe. In our experience, the AHLOs and AHNCs roles are an important and necessary component to addressing equity in health care for Aboriginal and Torres Strait Islander people and need to be resourced.

In the area of mental health, we recognise that being admitted to hospital for mental health care can be an anxious time for all of us, but for Aboriginal and Torres Strait Islander people it can be particularly stressful. In partnership with the Victorian Aboriginal Health Service (VAHS) – Family Counselling Service, St Vincent's Hospital Melbourne provides five dedicated beds in its mental health unit. This partnership has brought together the capabilities of two organisations to create a culturally safe environment for Aboriginal patients requiring inpatient mental health care that is complemented with the support of VAHS' Family Counselling Service, whereby patients are linked in to ongoing care and treatment in the community following discharge.

Another partnership initiative is with the Aboriginal Medical Service in Redfern and our St Vincent's Clinic Sydney, which aims provide patients with better access to care through bulk billing specialist services, particularly in the areas of orthopaedics and urology. In order to address the social, cultural and geographic barriers that prevent people accessing care, specialist clinicians from the hospital and clinic attend the Aboriginal Medical Service Redfern on a regular basis and also offer continuing education to the service's local clinical staff. Well over 100 patients have been assessed and treated by the clinicians since the inception of the clinic in 2011, and strong links have been developed between the Aboriginal Medical Service and the orthopaedic services team at St Vincent's Hospital Sydney.

One way St Vincent's Health Australia believes the provision of health services to Aboriginal and Torres Strait Islander people can be enhanced is to improve the professional standing of Aboriginal and Torres Strait Islander health, social and community workers as has been demonstrated by our partnership models and services above.

### ***Recommendations***

- That the Government put in place national workforce planning strategies that include the appropriate recognition of the role of Aboriginal and Torres Strait Islander health, social workers and community workers; and, appropriate pay, training and resources are made a priority to enable them to do their work effectively.

St Vincent's Health Australia would be keen to share with the Senate Select Committee the other exciting partnership initiatives that we are currently involved in, but more importantly we would like to identify areas where there are real opportunities on how Commonwealth funding can improve the provision of Indigenous health services. One area in particular that needs to be addressed is chronic kidney disease (CKD) and the service gaps in renal dialysis for rural and remote Aboriginal and Torres Strait Islander people. The facts on CKD for Aboriginal and Torres Strait Islander people are concerning:

- After adjusting for age differences, kidney disease is around 3.7 times more common among Indigenous people than among non-Indigenous people in Australia<sup>40</sup>.
- The incidence of end stage kidney disease for Indigenous peoples is especially high in remote and very remote areas of Australia, with rates almost 18 times and 20 times those of comparable non-Indigenous peoples.<sup>41</sup>
- Although Aboriginal and Torres Strait Islander people represent less than 2.5 per cent of the national population, they account for approximately 9 per cent of people commencing kidney replacement therapy each year.<sup>42</sup>
- Aboriginal and Torres Strait Islander people are almost 4 times as likely to die with CKD as a cause of death than non-Indigenous Australians.<sup>43</sup>

In response to this problem, St Vincent's Health Australia is currently examining and collaborating with partners on innovative approaches to address service equity and access issues for Aboriginal and Torres Strait Islander people, especially those who live in remote communities and are at a greater risk of developing CKD, and have substantially poorer health outcomes than other Australians. One partnership we are currently reviewing in the Northern Territory is how we can provide clinical care and support to assist Aboriginal and Torres Strait Islander people requiring haemodialysis to remain at home. One feasible option is the placing of a dialysis nurse in the community that is overseen by a clinical coordinator. As an organisation, we can foresee tangible benefits in partnering with an Aboriginal community service to increase access to dialysis therapies and reduce the dislocation from family, community and country. In addition, as more people are treated close to home, or even in their homes, the confidence of communities in therapies and their awareness of the disease will rise. We would welcome an opportunity to discuss with the Senate Select Committee how a co-contribution by the Government in this partnership model would address one of the highest health priorities for Aboriginal and Torres Strait Islander people, as well as, raise attention to the current complex and uncoordinated funding streams that disable funds to follow a dialysis patient that opts for an alternative mode of service delivery. What needs to be highlighted is that funding for Indigenous health needs to move from the focus of hospital services to community controlled health services that are increasing the numbers of people that are accessing healthcare.

### **Recommendations**

- That the Government investigate the development and funding of more regional models for providing continuous preventive, non-acute and acute specialist care to Aboriginal and Torres Strait Islander peoples with chronic disease in comprehensive community-controlled models. This investigation would need to consider management and coordination of the different Commonwealth and State funding streams involved to share the financial responsibilities for this initiative.
- That the Government investigate a co-contribution of funding with St Vincent's Health Australia and our Northern Territory partner to address chronic kidney disease and the service gaps in renal dialysis for rural and remote Aboriginal and Torres Strait Islander people in the Northern Territory.

<sup>40</sup> Australian Bureau of Statistics. Australian Aboriginal and Torres Strait Islander people Health Survey Updated results, Australia, 2012-13 . 2014

<sup>41</sup> Stumpers S, Thomson N. Review of kidney disease among Indigenous people. Australian Indigenous Health Bulletin 2013;13(2)

<sup>42</sup> Australian Bureau of Statistics. Australian Aboriginal and Torres Strait Islander people Health Survey Updated results, Australia, 2012-13 . 2014

<sup>43</sup> Australian Institute of Health and Welfare. Chronic Kidney Disease in Aboriginal and Torres Strait Islander people 2011. Canberra Australia: AIHW; 2011. Report No.: Cat. No. PHE 151

## f. Health Workforce Planning

### PRINCIPLES

#### St Vincent's Health Australia believes:

- **A national workforce strategy needs to be tailored to outcomes for communities, population need and the individual and the adoption of innovative work practices.**

The keys drivers for workforce demand include the growing burden of chronic disease, the higher numbers of people needing long term care and support, and the higher community expectations from health services. It is clear that our current national workforce size and makeup will not be able to deliver these same health services into the future.<sup>44</sup> The size of the Australian health workforce has never been larger, but, even to maintain the types of services that we currently have, numbers would need to treble.<sup>45</sup> This growth would need to occur in a context of dynamic global and local labour markets, where health competes with all other career options.

St Vincent's Health Australia believes that the workforce dilemma is more than just numbers, instead a paradigm shift in thinking is required about health system and workforce design and planning; this is by no means an easy task. Using the Person Centred Care principles that shape and direct St Vincent's Health Australia's model of care, a reform of the health workforce would require working backwards from outcomes for communities, population need and the individual, versus the current thinking that is generally focused on working forward from the base of existing professions and their interests and skills demarcations and responsibilities.

The challenge is to shape the new direction while supporting and improving the productivity of the existing system and workforce; attract and retain replacements for the retiring workforce; manage the generational shift of not working the same long hours or practising in the same way as predecessors; expand the size and nature of the workforce to care for the ageing population in light of the shrinking informal carer workforce; address the rural and remote workforce shortages; provide culturally appropriate care particularly to Aboriginal and Torres Strait Islanders and, manage the significant changes to health care delivery consequent on new technologies and advances in science and therapeutics and develop .

In addition to these challenges, is developing health leaders with competencies to uphold the values of patient safety and best practice, while remaining open to change and engaging with patients, residents, carers and communities to explore how best to meet their health care needs. At a system wide level, leadership competencies will be crucial from within the education and training systems, and at the senior political levels in health, education, labour/industrial relations and finance in order to support local leaders by minimising uncertainty, allowing some risk taking to enable innovation and supporting them through a significant time of change management.

Another key area for consideration is advancement in new technologies and the potential for the extension of professional boundaries to be undertaken in ways that maintain safe practice and at the same time free up the most highly skilled members of the workforce to concentrate on those areas where their specialised skills can most effectively be employed.

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<sup>44</sup> Productivity Commission (2005) Australia's Health Workforce. Productivity Commission Research Report; Productivity Commission (2005) Economic Implications of an Ageing Australia. Productivity Commission Research Report; Productivity Commission (2010) Caring for Older Australians Issues Paper).

<sup>45</sup> (NHRC (2009) Final Report p.61. [http://www.health.gov.au/internet/nhrc/publishing.nsf/Content/nhrc-report.](http://www.health.gov.au/internet/nhrc/publishing.nsf/Content/nhrc-report))



We would also like to bring to the Senate Select Committee's attention the policy changes in the higher education sector and the reductions in the 2014-15 Federal Budget, which will ultimately have an impact on the health workforce. Changes to the university funding arrangement may have a significant impact on the supply of health professionals and on the demographic composition of student cohorts - it is imperative that in any workforce strategy, the workforce reflects the community that it serves; this is particularly the case in health.

To be able to address these challenges, a national workforce strategy involving both macro level reforms in the health and education sectors supported by micro-level or local level organisational initiatives is required. Micro-level initiatives could include: redefinition and changes in job design and roles; inter-professional collaboration; accommodating overlapping professional boundaries; and, creation of supporting technologies and information systems. The recent report by the Grattan Institute *Unlocking skills of hospitals: better jobs, or care* examines the first of these micro level initiatives and recommends greater scope of practice for nurses, assistants and allied health workers in undertaking particular tasks whilst maintaining safety and quality of care. The report estimates savings of \$430 million a year for public hospitals that could fund treatment for more than 85,000 extra people.

Macro-level strategies would include: changes in educational approaches, occupational and industrial regulation, and health care financing and organisation. It is crucial that as a nation we have a debate about how our health care is financed and organised. Currently our health system continues to be dwarfed by the resources allocated to curative care through the public subsidising of medical services and pharmaceuticals which in turn, drives individuals to seek medical interventions and drugs as solutions to health problems, when in many cases offering alternative services may provide a more effective and less costly solution, particularly for chronic problems. This focus is actually counterproductive when introducing new models of care and service delivery and new roles to support people with chronic disease and, more importantly, hinders the move towards a focus on wellness and prevention. A national workforce strategy would need to examine the implications of such changes in the health system of the future.

St Vincent's Health Australia believes that such a long term workforce strategy will enhance the productivity of the existing and future workforce to meet current and emerging demands especially those in underserved areas. St Vincent's Health Australia would welcome an opportunity to contribute to the development of such a strategy.

### **Recommendations**

- That a national health strategic workforce plan be developed through strong Commonwealth national leadership, interagency collaboration and effective industry engagement, with particular reference to:
  - Increasing workforce productivity through the adoption of more innovative work practices.
  - Reviewing existing tertiary education systems so that they better support the delivery of quality training that is responsive and relevant to service needs.

#### **g. Any related measures**

St Vincent's Health Australia notes that there are a range of related reviews that are occurring concurrently by the Commonwealth Government that the Senate Select Committee on Health should be cognisant of in their report on health policy, administration and expenditure. Of key importance is the White paper on the Reform of the Federation to be released in 2015 and the associated health issues paper expected to be realised later in this year.

In addition, there have been a number of key reviews that have been undertaken such as the: Senate Community Affairs Committee on the social determinants of health and Australia's domestic response to the World Health Organization's (WHO) commission report, *Closing the gap within a generation*; and, the Community Affairs References Committee report into out of pocket costs in Australian healthcare, and others currently in process such as the review of mental health services and programs, the review of competition policy and the review of after-hours primary health care services in Australia, all of which will provide a rich source of information to guide the longer term strategic solution to health care.

Given the long term timeframes for this Committee to report, St Vincent's Health Australia would welcome further opportunities to comment.

End.

25 September 2014