

*Senate Finance & Public Administration References Committee: Inquiry
into COAG Reforms Relating to Health & Hospitals*



Public Health Association
AUSTRALIA

**Submission from the Public Health Association of Australia to
the Senate Finance and Public Administration References
Committee**

Inquiry into COAG Reforms Relating to Health and Hospitals

Senate Finance and Public Administration
References Committee
PO Box 6100
Parliament House
CANBERRA ACT 2600

Phone: (02) 6277 3530
Fax: (02) 6277 5809
Email: fpa.sen@aph.gov.au

1 June 2010

*Senate Finance & Public Administration References Committee: Inquiry
into COAG Reforms Relating to Health & Hospitals*

Contents

Introduction..... 3

Summary/Background..... 4

Terms of Reference 5

 Community Health in Operation 5

 Ensuring Emphasis on Prevention 8

 The Broader Policy Framework for Primary Health Care and Addressing Health Inequities 9

Conclusion 10

Senate Finance & Public Administration References Committee: Inquiry into COAG Reforms Relating to Health & Hospitals

Introduction

The Public Health Association of Australia Incorporated (PHAA) is recognised as the principal non-government organisation for public health in Australia and works to promote the health and well-being of all Australians. The Association seeks better population health outcomes based on prevention, the social determinants of health and equity principles.

The PHAA is a national organisation comprising around 1500 individual members and representing over 40 professional groups concerned with the promotion of health at a population level. This includes, but goes beyond the treatment of individuals to encompass health promotion, prevention of disease and disability, recovery and rehabilitation, and disability support. This framework, together with attention to the social, economic and environmental determinants of health, provides particular relevance to, and expertly informs the Association's role.

Key roles of the organisation include capacity building, advocacy and the development of policy. Core to our work is an evidence base drawn from a wide range of members working in public health practice, research, administration and related fields who volunteer their time to inform policy, support advocacy and assist in capacity building within the sector. The PHAA has been a key proponent of a preventive approach for better population health outcomes championing such policies and providing strong support for the government and for the Preventative Health Taskforce and NHMRC in their efforts to develop and strengthen research and actions in this area across Australia.

The PHAA has Branches in every State and Territory and a wide range of Special Interest Groups. The Branches work with the National Office in providing policy advice, in organising seminars and in mentoring public health professionals. This work is based on the agreed policies of the PHAA. Our Special Interest Groups provide specific expertise, peer review and professionalism in assisting the National Organisation to respond to issues and challenges as well as a close involvement in the development of policies. In addition to these groups the Australian New Zealand Journal of Public Health draws on individuals from with the PHAA who provide editorial advice, review and who edit the Journal.

In recent years the PHAA has further developed its role in advocacy to achieve the best possible health outcomes for the community, both through working with all aspects of government and promoting key policies and advocacy goals through the media and other means.

This submission has been developed on behalf of the PHAA by the Primary Health Care Special Interest Group, which is convened by Professor Helen Keleher, Head of the Department of Health Social Science at the School of Public Health and Preventive Medicine, Monash University.

Senate Finance & Public Administration References Committee: Inquiry into COAG Reforms Relating to Health & Hospitals

Summary/Background

Whilst PHAA is supportive of much of the COAG Agreement, and the new National Primary Health Care Strategy (NPHCS), we feel there is strong danger that one of the most effective and equitable parts of the current system may be lost, namely the community health service model operating in Victoria and South Australia. Community health services and programs should be at the heart of an improved primary health care system, not be threatened by it. The breadth of community health programs is integral to achieving the vision of the Preventative Health Taskforce for a reduction in chronic disease. Many such services already provide working examples of the integrated comprehensive primary health care service strongly recommended by the National Health and Hospitals Reform Commission (NHHRC). That vision for comprehensive primary health care services has only weakly been included in the NPHCS, which is more focused on episodic primary medical and allied health services.

Senate Finance & Public Administration References Committee: Inquiry into COAG Reforms Relating to Health & Hospitals

Terms of Reference

PHAA's submission relates specifically to the following Terms of Reference:

- (d) the \$15.6 billion top-up payments guaranteed to the states by the Commonwealth in the period 2014-15 to 2019-20, including exploring the breakdown of expenditure relating to hospitals, outpatient services, capital expenditure, GP and primary healthcare, aged care and other areas of health expenditure;
- (j) mental health matters; and
- (k) any other related matter.

Community Health in Operation

There is a widespread view that the current health care system is not meeting needs and requires reform. This sweeping view does not apply to all parts of the system. The community health sector, whilst needing some enhancement, is one of the successes of the Australian health system, and should be built upon, not dismantled or reconfigured to meet a broader agenda. Indeed, the community health sector offers an excellent model for moving forward with the visions and goals for prevention and reduction in emergency department use and hospital admissions.

Community Health provides comprehensive primary health including health promotion and disease prevention programs as well as nursing and allied health, and ideally with medical care (although unfortunately this is not financially feasible under current arrangements for many services). Care is crucially organised on team-based models of care, where service is provided by the most appropriate professionals working together, not just by those that are subsidised by the Medicare Benefits Schedule (MBS) or affordable to the consumer. With increasing levels of social disadvantage, affordable, accessible community health services and programs are accessed by thousands of people who find the models of service delivery to be more appropriate and accessible for their holistic care than the separated and individualist fee-for-service model of most of the primary care sector.

Without community health services caring for those with the worst health status in our society, the needs of many thousands of Australians might otherwise be under-served by the remainder of the general practice and private allied health focussed services. Although this latter sector is staffed by excellent professionals, the funding and private sector nature of it means that it is often fragmented, (mal)distributed according to market logic rather than health need, is often unaffordable to people on lower than average incomes, and cannot provide the kinds of tailored and innovative team-based services for disadvantaged Australians offered by community health.

Senate Finance & Public Administration References Committee: Inquiry into COAG Reforms Relating to Health & Hospitals

Indeed all Australians should have access to these programs, as recommended by the NHHRC. Community health programs integrate and coordinate care for people living with chronic conditions and reduce preventable hospital admissions. They undertake projects and programs that build the capacity of individuals and groups to improve their health literacy, take charge of their health, develop community connections and be agents of change in their local catchment. Community health services in Australia have been at the forefront of developing effective models of primary health care. They have been characterized by a focus on:

- equity;
- prevention of illness and promotion of health through a social model of health service delivery that takes account of people's environments, level of education and literacy, and family circumstances;
- provision of a broad range of basic health care services where people live and work, free or at low cost;
- use of multidisciplinary teams of health workers;
- the use of community development to build local capacity for health; and
- community involvement in the governance of the service.

Aboriginal Community-Controlled Health Services (ACCHSs) in particular have provided a model for making local health services responsive to local needs, crucially including cultural needs. These kinds of programs are essential to create social inclusion and keep people connected to their communities. ACCHSs provide primary health care services and programs that are not appropriate for funding through the private sector business model of primary care. These services provide a service model for all Australians and go beyond those offered by primary medical services to offer a more comprehensive set of services and population health responses.

Currently our health care system is focused on the treatment of acute and chronic illness through general practice and hospitals. There is an acknowledged lack of coordination between these services and between them and other primary health care and community care services. The community health model is a basis for a more integrated model that does not see the domination by one particular profession.

It is true that community health services do operate within a constrained system and hence there is room for improvement in their work. A key constraint is the spaghetti of funding arrangements they currently need to access. The Commonwealth taking responsibility for all primary health care funding does provide an excellent opportunity for streamlined and simplified funding towards models of better care. PHAA supports a gradual move away from the fee-for-service MBS model for community health and allied health services to blended payments systems (as proposed by NHHRC and the NPHCS) with regard to funding to primary health care services, consistent with PHAA policies.

Senate Finance & Public Administration References Committee: Inquiry into COAG Reforms Relating to Health & Hospitals

However, in PHAA's view, there are also a number of important questions that remain to be addressed in relation to the operation of the new reforms relating to health and hospitals:

Question 1

The new National Healthcare Agreement indicates that the states and territories will be responsible for funding of Community Health Services. However, the Commonwealth will be the 'dominant' funder for hospital services.

How will the Agreement improve coordination and continuity of care between hospital services and community health services?

Question 2

Given that states and territories will be responsible for funding of Community Health Services,

How will the Agreement ensure that States continue to fund these essential services?

Question 3

The Australian Health Care Agreements (AHCAs) are proposing Medicare Locals (MLs) as a new form of network change agent but also funder and even service provider. Although we support the potential roles of bodies like MLs, especially for population health planning and promoting change towards a primary health care model, clarification is needed regarding the potential scope of their roles.

There appears to be a set of potentially conflicting roles announced for the new MLs, from being change agents, to service planning, to coordination, to funding allocation, and even to service delivery. Questions arising might include:

Question 3A: How will structures facilitate cooperation across these roles?

Question 3B: How will MLs relate to the current structure of the Divisions of General Practice?

Question 3C: Would it be more appropriate to create a new structure rather than establish a blended structure?

Question 3D: What will be the relationship between MLs and the proposed new Hospital Networks?

Question 3E: Where will population health planning occur on the basis of appropriate public health expertise?

Senate Finance & Public Administration References Committee: Inquiry into COAG Reforms Relating to Health & Hospitals

Question 3F: How will community health services and their long history of experience and commitment to working with underserved and disadvantaged populations, be built upon and expanded under a ML model?

Question 4

One of the disconnects in the primary health system has been the low rate of referral by GPs to community health programs of clients who would benefit from programs such as chronic disease self management, nutrition support and education, alcohol and drug programs and sexual and reproductive health.

How will the proposed MLs guarantee that these essential programs are strengthened and not sacrificed to fee for service models?

Ensuring Emphasis on Prevention

PHAA supports the seven Strategic Directions established by the Preventative Health Taskforce in the National Preventative Health Strategy. Namely:

1. **Shared responsibility** – developing strategic partnerships – at all levels of government, industry, business, unions, the non-government sector, research institutions and communities
2. **Act early and throughout life** – working with individuals, families and communities
3. **Engage communities** – act and engage with people where they live, work and play; at home, in schools, workplaces and the community. Inform, enable and support people to make healthy choices
4. **Influence markets and develop coherent policies** – for example, through taxation, responsive regulation, and through coherent and connected policies
5. **Reduce inequity through targeting disadvantage** – especially low socioeconomic status (SES) population groups
6. **Indigenous Australians** – contribute to ‘Close the Gap’
7. **Refocus primary health care towards prevention**

Australia: The Healthiest Country by 2020 – National Preventative Health Strategy

PHAA is pleased to note the reaffirmation of the Government’s commitment to refocusing the health system towards prevention in its response to the report of the National Preventative Health Taskforce, released in May 2010.

Senate Finance & Public Administration References Committee: Inquiry into COAG Reforms Relating to Health & Hospitals

However, PHAA also notes that in order to reach the prevention targets outlined in the Taskforce report, the proportion of health expenditure dedicated to public health and prevention activities will need to be substantially increased.

According to the Australian Institute of Health and Welfare (AIHW):

“A widely used definition of public health in Australia is ‘the organised response by society to protect and promote health, and to prevent illness, injury and disability; the starting point for identifying public health issues, problems and priorities, and for designing and implementing interventions, is the population as a whole, or population subgroups’ (NPHP 1998). The term ‘public health’ is often used interchangeably with ‘population health’ and ‘preventive health’.

In essence, public health interventions focus on prevention, promotion and protection rather than on treatment; on populations rather than on individuals; and on the factors and behaviours that cause illness. Using a range of sources, the AIHW has estimated that around \$1.5 billion was spent by governments on public health activities in Australia in 2005–06, representing 1.8% of total health expenditure.”

Australia’s Health 2008, AIHW.

The Prime Minister described the current proportion of overall health expenditure dedicated to public health activities as “crazy” in an address to the *Australia 2020* Summit in April 2008.

While the growing whole-of-government focus on prevention initiatives at both the Commonwealth and jurisdictional levels means that the above estimate may understate current levels of cross-portfolio expenditure on public health and prevention activities, it is clear that expenditure on these activities will need to increase in order to achieve the goal of refocusing the health system towards prevention.

The Broader Policy Framework for Primary Health Care and Addressing Health Inequities

PHAA has developed specific policies on the broader issues of Primary Health Care and Health Inequities that provide a broad framework for the specific input contained in this submission. Copies of these two policies are provided at Attachments A and B.

Senate Finance & Public Administration References Committee: Inquiry into COAG Reforms Relating to Health & Hospitals

Conclusion

PHAA is keen to ensure that community health services and programs are at the heart of an improved primary health care system. The breadth of community health programs based on a social model of health rather than a primary care model, is integral to achieving the vision of the Preventative Health Taskforce.

PHAA's submission raises a series of questions in relation to the operation of the COAG reforms to health and hospitals and reaffirms our commitment to ensuring an emphasis on prevention within the broader policy framework of delivering quality primary health care and addressing health inequities.

Please do not hesitate to contact PHAA should the Committee require additional information in relation to this submission.

1 June 2010
Professor Helen Keleher
Convenor, PHAA Primary Health Care Special Interest Group