



2017–18 Pre-Budget Submission to Treasury

January 2017

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Introduction

The Australian Healthcare and Hospitals Association (AHHA) welcomes this opportunity to provide a submission in advance of the 2017–18 Australian Government Budget.

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

Ongoing renewal and reform are features of the Australian health system, driven both by budget pressures and a desire for system improvement. Australians place high value on universal access to a quality health system. To meet this expectation, Budget 2017–18 must ensure its health policies and reforms will continue to support an effective, accessible, equitable and sustainable healthcare system focused on quality outcomes.

It is imperative that short-term measures do not have long reaching adverse consequences for the health of Australians. In the field of healthcare, imprudent savings made in the current budget cycle can manifest in poorer individual health outcomes and an increased burden on the healthcare system in the future.

The most recent healthcare expenditure data shows how growth in healthcare spending is increasingly being redistributed away from government towards non-government sources. In 2014-15, total health expenditure by the Australian Government rose in real terms by 2.4 per cent over the year. This was the third consecutive year that growth in health expenditure was below the 10-year average (4.0 per cent between 2004–05 and 2014–15). In 2014–15, non-government sources (individuals, private health insurance and other non-government sources) contributed 33.1 per cent of total health spending, up from 32.2 per cent the previous year. Growth in non-government expenditure in 2014–15 of 5.9 per cent was higher than for governments, and above the average annual growth over the decade of 5.4 per cent. Despite the low growth in total health expenditure in 2014-15, the share of the economy represented by health reached 10.0 per cent of Gross Domestic Product for the first time.¹

While health expenditure has increased as a proportion of total government tax revenue from 25.0 per cent in 2013-14 to 26.4 per cent in 2014-15, this was partially a result of a fall in Australian Government tax revenues of 1.5 per cent in 2014-15.² AHHA maintains that financing of the health sector must not be determined in the context of cyclical variations in the economy, but with a view to the long term benefits of a well-functioning and appropriately funded healthcare system. While healthcare expenditure continued to grow in 2014-15, this was at a rate much lower than the previous five and ten year averages and was associated with an increasing proportion financed through non-government sources.

¹ Australian Institute of Health and Welfare (AIHW). 2016a. Health expenditure Australia 2014–15. Health and welfare expenditure series no. 57. Cat. no. HWE 67. Canberra: AIHW.

² *Ibid.*

It should also be noted that the health and social assistance sector is Australia’s largest employer, ahead of the retail, construction and manufacturing sectors. Recent analysis of Australian Bureau of Statistics employment data by Bankwest found that the health and social assistances sector’s share of employment has grown from 8.5 per cent to just over 12.5 per cent in the past 25 years.³ The contribution of the health sector to the economy, beyond supporting a healthy and productive workforce, is substantial.

Any reform to the healthcare and related systems must be considered as part of a co-ordinated approach to the delivery of care across the primary, acute, aged and disability care sectors. In particular, no further cuts to health expenditure spending should be made until the various review processes currently underway are completed and can be assessed in a coordinated manner. These include reviews and consultations on the MBS, the Fifth National Mental Health Plan, private health insurance, redesigning the Practice Incentives Program and the National Digital Health Strategy.

Most of the recommended budget measures and policy directions that we present do not seek new or additional funding, but rather propose to more sensibly target and organise the existing health infrastructure Australia has in place. They also emphasise the need for better coordination across primary, acute, aged and disability care sectors with both the efficiencies and better patient outcomes this can produce.

³ Ong T. 5 January 2017. Health sector remains Australia's biggest employer. ABC News. Available at: <http://linkis.com/www.abc.net.au/news/TIYlj>.

Summary of Recommendations

Policy Area	Government Action Required
Funding for value and outcomes in healthcare	<ul style="list-style-type: none"> - Funding for healthcare should be based on achieving value and health outcomes - A national minimum data set for primary health care and related health outcomes indicators should be developed
Health Care Home implementation	<ul style="list-style-type: none"> - Provide appropriate levels of funding for the Health Care Home payment tiers to ensure the level of care needed is received, and for the sustainability of participating general practices and Aboriginal community controlled health services - Develop payments and incentives within the Health Care Home to encourage connectivity between practices and service providers - Develop and provide support for practices and service providers to ensure a successful transition to the new business model - Develop and provide information and education to consumers who may be eligible to enrol in the Health Care Home. - Work with the states and territories to consider the pooling of funding, particularly to address preventable hospitalisations and to promote innovative models of care - Provide prospective practices and services with a tool that enables them to assess the overall revenue impact from moving to bundled payments for a cohort of their patients to encourage participation in the Health Care Home program - Leverage the role and expertise of the Primary Health Networks (PHNs), and ensure PHNs have appropriate funding to guide the successful implementation of the Health Care Home - Develop a purpose-built national minimum data set for primary healthcare
Public hospital funding from 1 July 2020	<ul style="list-style-type: none"> - The agreement between the Commonwealth, state and territory governments on funding of public hospitals from 1 July 2020 must continue to be based on activity based funding, with the Independent Hospital Pricing Authority continuing to determine the Nationally Efficient Price and Cost - A reform commission should be established to develop a post-2020 agreement, and to develop strategies to improve integration of healthcare services, remove waste and duplication within and across sectors, and to identify low value healthcare
Improving the interface between health, aged care and disability services	<ul style="list-style-type: none"> - Update the Australian Institute of Health and Welfare report on movement between hospitals and residential aged care to better understand contemporary issues around the use of hospitals, and transitions between hospitals, community and residential aged care - Examine the international evidence for funding-by-outcomes and funding-for-results with a view to application within Australia - Establish better channels of cross-sector communication and cooperation among funders, consumers, providers and stakeholders, including the integration of the My Aged Care, NDIS and My Health Record portals - Consider reforms to current funding arrangements and associated reporting mechanisms to encourage disability, aged care, community and health services to better identify and support complex care needs

Policy Area	Government Action Required
My Health Record opt-out trial extended to all Australians	<ul style="list-style-type: none"> - The My Health Record opt-out trial should be extended to all Primary Health Networks (PHNs) - Additional specific funding should be provided to each PHN to lead this work
Oral health	<ul style="list-style-type: none"> - Restore interim funding for the National Partnership Agreement for public dental services to adults at \$155 million per year - Restore funding for the Child Dental Benefits Schedule to a maximum benefit of \$1,000 over two years to eligible children - Extend eligibility for public dental services beyond concession card holders to lower income Australians - Develop a performance and reporting structure focusing on outcomes rather than throughput - Appoint an Australian Chief Dental Officer to coordinate oral health policy
Better use of medicines and treatments	<ul style="list-style-type: none"> - Continue the Medicare Benefits Schedule Review currently underway, and link in with work separately being undertaken by the National Prescribing Service (NPS) on the Choosing Wisely initiative. - Ensure alignment of NPS work in promoting evidence based use of medicines and treatments with the Primary Health Network roles in developing regional health pathways and supporting capability development in general practice.
Pharmaceuticals and pharmacy	<ul style="list-style-type: none"> - Reform in the pharmaceutical and pharmacy sector must be considered as part of a coordinated approach to achieving the objectives of the National Medicines Policy. - A health workforce strategy developed to ensure that pharmacists (along with all the health workforce) are utilised to the full scope of their professional expertise
Private health insurance	<ul style="list-style-type: none"> - Ensure that the review of private health insurance realises: <ul style="list-style-type: none"> · Simpler products; · Better communication with policy holders; · Removal or better application of the private health insurance rebate to safe and effective evidence-based treatments; · Policies which meet consumer need; · Better business practices; · Equity and accessibility assurance for the non-insured; · The right of privately-insured hospital patients to choose their own doctor, whether in a private or public hospital; and · The continued ability to use private insurance in public hospitals - Simplified health insurance policies must ensure that the lowest cost category does not discriminate against women, people with chronic disease or disadvantaged population groups by excluding coverage of particular services - The reform of private health insurance must include broad consultation across both the public and private sectors
Health workforce	<ul style="list-style-type: none"> - Develop national policy directions on health professional and practitioner scopes of practice that will enable a coordinated, safe and efficient response to changes in the demand for health services and innovation in models of care.
Preventive healthcare	<ul style="list-style-type: none"> - Prioritise developing and implementing preventive health strategies, with a particular focus on overweight and obesity, alcohol misuse and abuse, tobacco

Policy Area	Government Action Required
	<p>consumption, inequality and immunisation</p> <ul style="list-style-type: none"> - Funding for preventive health should be increased to at least 2.3 per cent of recurrent health spending, with a proportion of this quarantined for expenditure through Primary Health Networks for locally targeted initiatives responding to areas of community need - Investment is needed in a broad array of evidenced-based strategies to discourage the consumption of sugar-sweetened beverages including: <ul style="list-style-type: none"> · Measures to regulate availability · Improving labelling · Restricting promotion · Reducing consumption · Increasing public awareness of the potential harm · Implementing a 20 per cent ad valorem sugar-sweetened beverages tax - Revenue raised from a sugar-sweetened beverages tax should be hypothecated for preventive health measures.
Control of rheumatic heart disease in Aboriginal and Torres Strait Islander Peoples	<ul style="list-style-type: none"> - Case management of people with acute rheumatic fever and their families involving both clinical and social assessments. - Support for secondary prophylaxis outreach to provide regular antibiotic injections. - A national register for rheumatic heart disease.
End of life planning	<ul style="list-style-type: none"> - A nationally consistent legislative framework to support end-of-life decision-making - Enhanced integration of advance care planning documents in My Health Record with primary, hospital and community health IT systems - System-wide transformation of palliative care services and models of care to better respond to end-of-life needs and to meet increasing demand, coordinating and integrating these changes across primary, community, specialist and hospital care - An MBS item to support the central involvement of GPs in end-of-life planning - End-of-life planning included in the accreditation and quality framework
Social impact investing	<ul style="list-style-type: none"> - The Commonwealth work with state and territory health departments and Primary Health Networks to pilot small scale social impact investing initiatives tied with research components to establish an Australian evidence base on the effectiveness of this novel financing model
Unlegislated measures carried forward in the Budget estimates	<ul style="list-style-type: none"> - Pharmaceutical Benefits Scheme and Medicare measures announced in the 2014-15 Budget that have not been legislated but remain in the forward estimates should be removed

1 Funding for value and outcomes in healthcare

Key Recommendations:

- Funding for healthcare should be based on achieving value and health outcomes.
- An initial investment of \$5 million should be made to develop a national minimum data set for primary health care and related health outcomes indicators.

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

The AHHA supports a performance and reporting structure focusing on outcomes, rather than throughput, through the development of indicators, which could then be tied to outcomes based funding when more timely and robust data collection and dissemination is in place to enable such a change. This performance and reporting structure should also be consistent across services (e.g. general practice, pharmacy, allied health, community health services etc) to enable comparisons to be made of innovations in scopes of practice and role substitution. The use of proxy indicators and data that are not fit for purpose do not adequately meet this objective. The Primary Health Care Advisory Group has also recommended the establishment of a national minimum data set for patients with chronic and complex conditions.⁴

AHHA therefore calls for the Government to invest in the development of a set health outcomes indicators and related national minimum data set for primary healthcare. This is an activity that the Australian Institute of Health and Welfare could lead with a suggested initial investment by the Government of \$5 million. This modest investment would initiate a process of transition in the way primary healthcare is focussed from volume to outcomes, and would also be beneficial in assessing performance of the Health Care Homes.

⁴ Primary Health Care Advisory Group. 2015. Better Outcomes for People with Chronic and Complex Health Conditions. Primary Health Care Advisory Group Final Report. Commonwealth of Australia.

2 Health Care Home implementation

Key Recommendations:

- Provide appropriate levels of funding for the Health Care Home payment tiers to ensure the enrolled health consumers receive the level of care needed and for the sustainability of participating general practices and Aboriginal community controlled health services (ACCHSs).
- Develop payments and incentives within the Health Care Home to encourage connectivity between practices and service providers.
- Develop and provide support for practices and service providers to ensure a successful transition to the new business model.
- Develop and provide information and education to consumers who may be eligible to enrol in the Health Care Home.
- Work with the states and territories to consider the pooling of funding, particularly to address preventable hospitalisations and to promote innovative models of care.
- Provide prospective practices and services with a tool that enables them to assess the overall revenue impact from moving to bundled payments for a cohort of their patients to encourage participation in the Health Care Home program.
- Leverage the role and expertise of the Primary Health Networks (PHNs), and ensure PHNs have appropriate funding to guide the successful implementation of the Health Care Home.
- As a matter of urgency, develop a purpose-built national minimum data set for primary healthcare.

With 23 per cent of Australians suffering from two or more chronic conditions (based on eight of the most common chronic diseases), the development and implementation of the Health Care Home is a welcome step in the right direction to resolving fragmented and poorly integrated primary and acute care services for people with chronic conditions.⁵

Once the Health Care Home model of care is rolled-out nationally, the program should be expanded by 2018-19 to support the 50 per cent of Australians with at least one chronic disease.⁶

The establishment of Health Care Homes across Australia, which the Primary Healthcare Advisory Group's report finds will provide continuity of care, coordinated services and a team-based approach according to the needs and wishes of the patients, builds on the efforts of PHNs that are already developing such services in their areas. However, well delivered coordinated care typically involves larger upfront costs, while the large gains from the mitigation and better management of chronic disease may only be realised over the longer term.

The key role being attributed to general practice in leading the Health Care Home reform requires their active support and engagement to ensure greater use of the My Health Record and collaboration in the development of a purpose-built national minimum dataset. PHNs also have an important role in leading this work in partnership with their Clinical Councils, Community Advisory Committees and local general practices.

⁵ Australian Institute of Health and Welfare (AIHW). 2016b. Australia's health 2016. Australia's health series no. 15. Cat. no. AUS 199. Canberra: AIHW.

⁶ *Ibid.*

The Health Care Homes must be appropriately funded to achieve their stated objectives. There are concerns that the current funding arrangements for the first stage of implementation of Health Care Homes will not be sufficient for the level of care needed and for the sustainability of general practices participating in this program. This is particularly the case given the implementation of the first stage is occurring in an environment where there has been a freeze on the indexation of Medicare fees for several years, and noting that only a limited proportion of a practice's patients will be involved in the program, thus requiring parallel business models to be put in place in the practice.^{7,8,9}

To be most effective, there should be payments and incentives to encourage connectivity between practices and service providers. By contrast, the current fee-for-service model of care does not cover healthcare team meetings as has been recently observed, for example, in some United States primary healthcare settings. Incentives may be required to encourage change to clinical practices.

Some general practices may also need support and assistance in moving to the new business model required to support patient-centred and team-based healthcare. Likewise, the tension between patient choice and the advantages of having a patient enrolled with a single practice will need to be addressed through a communications strategy aimed at providing information and education to consumers who may be eligible to enrol in Health Care Homes.

The Health Care Homes will not be sustainable unless the business model for participating general practices and ACCHSs is also sustainable. In order to assess the financial implications of participating in the initiative, a tool should be made available by the Department of Health to enable prospective practices to effectively assess the business implications and viability of becoming a Health Care Home given their varying local circumstances.

Purposeful collaboration with state and territory governments will also be necessary, as foreshadowed by the Council of Australian Governments Heads of Agreement of 1 April 2016. This should include opportunities to consider pooling of funding, particularly to address preventable hospitalisations and to promote innovative models of care. Any savings achieved should then be shared between both levels of government to provide appropriate financial incentives.

A purpose-built national minimum data set for primary healthcare is also essential. The use of proxy indicators and data that are not fit for purpose is sub-optimal. This must be implemented as a matter of urgency as it will be difficult to evaluate the first phase of the Health Care Home implementation without this.

⁷ Rollins, A. Penny pinching threatens chronic care reform. Australian Medicine. 8 Nov 2016. Available at: <https://ama.com.au/ausmed/penny-pinching-threatens-chronic-care-reform>.

⁸ Gannon, M. Health Care Home truths. Australian Medicine. 22 Nov 2016. Available at: <https://ama.com.au/ausmed/health-care-home-truths>.

⁹ RACGP media release. Government fails to deliver on Health Care Home. 6 Nov 2016. Available at: [http://www.racgp.org.au/yourracgp/news/media-releases/government-fails-to-deliver-on-health-care-homes-\(1\)/](http://www.racgp.org.au/yourracgp/news/media-releases/government-fails-to-deliver-on-health-care-homes-(1)/).

3 Public hospital funding from 1 July 2020

Key Recommendations:

- The agreement between the Commonwealth, state and territory governments on funding of public hospitals from 1 July 2020 must continue to be based on activity based funding, with the Independent Hospital Pricing Authority continuing to determine the Nationally Efficient Price and Cost as a fully independent and appropriately funded body.
- A reform commission should be established to develop a post-2020 agreement, and to develop strategies to improve integration of healthcare services, remove waste and duplication within and across sectors, and to identify low value healthcare.

The Council of Australian Governments (COAG) meeting on 1 April 2016 agreed on short-term funding contributions by the Commonwealth to states and territories for public hospitals. This agreement also requires a long-term public hospital funding agreement to be considered by COAG by September 2018.

In negotiating this funding agreement between the Commonwealth, state and territory governments to apply from 1 July 2020, AHHA calls on the Government to ensure the following principles are adhered to:

- Public hospital funding will continue to be provided on the basis of activity based funding, with block funding for smaller public hospitals as appropriate
- The Independent Hospital Pricing Authority retains its role in determining the National Efficient Price (and associated weighted activity units) and the National Efficient Cost as a fully independent and appropriately funded body

The Australian Government should also establish a commission tasked with leading the development of the post-2020 funding agreement, and strategies to improve integration of healthcare services, removing waste and duplication within and across sectors, and identifying low value healthcare. This would lead to both system efficiencies and better patient care. This commission could also be tasked with ensuring recommendations from the various reviews of the health sector currently being conducted are implemented in a coordinated manner that do not create adverse impacts on other parts of the system.

4 Improving the interface between health, aged care and disability services

Key Recommendations:

- Investment to update the Australian Institute of Health and Welfare report on movement between hospitals and residential aged care¹⁰ to better understand contemporary issues around the use of hospitals, and transitions between hospitals, community and residential aged care.
- Examining the international evidence for funding-by-outcomes and funding-for-results with a view to application within Australia. This will include sector and community consultation.
- The establishment of better channels of cross-sector communication and cooperation among funders, consumers, providers and stakeholders. This should include integration of the My Aged Care, NDIS and My Health Record portals.
- The Government considers reforms to current funding arrangements and associated reporting mechanisms to encourage disability, aged care, community and health services to better identify and support complex care needs.

Reforms to improve the coordination between health, aged care and the disability services must be considered to improve integration and provide person-centred care for those people requiring services across some or all of these sectors.

The Australian healthcare and social welfare sectors are under-prepared to deal with rising rates of chronic disease, disability and an ageing population. Government responses to these issues have included the establishment of programs such as the Health Care Home trials to be rolled-out across ten Primary Health Network regions, individual aged care funding packages and the National Disability Insurance Scheme (NDIS). Although such innovations are welcomed by the AHHA, care across the disability, aged care, community services and health sectors remains fragmented in terms of service delivery and funding responsibilities. System changes are needed to ensure the delivery of comprehensive and integrated person-centred care, with appropriate communication and transitions between care providers.

Providing integrated and coordinated care across the entirety of the patient journey will yield the best outcomes for patients, providers and systems, as well as generate system efficiency gains. There are opportunities to implement a range of measures to achieve these efficiencies including:

- Better evidence on the transitions between community and residential aged care and hospitals. This could be affected by the Australian Institute of Health and Welfare being tasked with updating the most recent (2008–09) report on transitions between hospitals and aged care.¹⁰
- A performance and funding structure focussing on outcomes and results, rather than throughput.
- Development of shared and defined policy objectives for optimising care and outcomes for people requiring services across some or all of these care sectors.
- Early identification and prevention to ensure access to timely care for those with complex care needs.

These proposals could be funded from existing resources, supplemented with an additional investment of \$5 million.

¹⁰ AIHW. 2013. Movement between hospital and residential aged care 2008-09. Data linkage series 16. Cat. no. CSI 16. Canberra: AIHW.

5 My Health Record opt-out trial extended to all Australians

Key Recommendations:

- The My Health Record opt-out trial should be extended to all Primary Health Networks (PHNs).
- Additional specific funding should be provided to each PHN to lead this work.

The My Health Record opt-out trial has been held in two PHNs since March 2016 and has achieved unexpected success in achieving uploads of health summaries with acceptance from both individuals and providers.¹¹ The importance of achieving strong uptake and use of My Health Records is because it, “reduces occurrences of adverse medical events; decreases in the number of tests; and less duplication and better coordination and quality of health care”.¹²

The evaluation of this opt-out trial, in tandem with a separate opt-in trial, was to be provided to the Government by November 2016.¹³ If the findings of this evaluation are favourable, AHHA calls on the Government to allocate additional specific funding to extend this change in participation arrangements to all PHNs not part of the current opt-out trial. This investment will ensure that this important element of health management infrastructure is provided to the entire Australian population.

¹¹ Bowles M. 2016. Trials indicate increasing patient confidence in My Health Record. Australian Financial Review, 6 November 2016. Available at: <http://www.afr.com/news/special-reports/future-of-healthcare/trials-indicate-increasing-patient-confidence-in-my-health-record-20161104-gsic1h>.

¹² Department of Health. 2016. Annual Report. Commonwealth of Australia. p 6.

¹³ *Ibid.* p 136.

6 Oral health

Key Recommendations:

- The Government should restore interim funding for the National Partnership Agreement for public dental services to adults at \$155 million per year—in line with calendar year 2016 funding levels.
- Restore funding for the Child Dental Benefits Schedule to a maximum benefit of \$1,000 over two years to eligible children.
- Extend eligibility for public dental services beyond concession card holders to lower income Australians.
- A performance and reporting structure focusing on outcomes rather than throughput should be developed.
- Appoint an Australian Chief Dental Officer to coordinate oral health policy.

AHHA recommends the restoration of Commonwealth interim funding for the National Partnership Agreement for public dental services to adults at \$155 million per year—in line with calendar year 2016 funding levels—until a new National Partnership Agreement is agreed by Commonwealth, state and territory governments.

AHHA recommends the restoration of Commonwealth funding for the Child Dental Benefits Schedule (CDBS) to a maximum benefit of \$1,000 over two years to eligible children.

AHHA recommends the extension of public dental services eligibility beyond concession card holders to lower income Australians as part of the negotiations between the states and territories and the Commonwealth on the funding for public dental services.

AHHA supports a performance and reporting structure focusing on outcomes, rather than throughput, through the development of oral health indicators. This should then be tied to outcomes based funding when more timely and robust data collection and dissemination is in place to enable such a change. Investment in this data and indicator development work should be prioritised in 2016-17. The estimated cost of developing this framework is \$1.0 million.

AHHA calls for the appointment of an Australian Chief Dental Officer to provide national coordination of oral health policy development and implementation of the National Oral Health Plan. This should be funded from 2017–18. The estimated cost of such an appointment is \$0.5 million per annum.

Funding allocations must reflect the full cost of providing care in rural and remote areas, smaller jurisdictions and to groups with high needs.

Good oral health is fundamental to health, wellbeing and quality of life. A healthy mouth enables people to eat, speak and socialise without pain, discomfort or embarrassment. Oral health problems impact on general health. As a common risk factor for chronic diseases, oral disease is significantly associated with cardiovascular disease, diabetes, stroke and respiratory disease. Poor oral health can also impact on birth outcomes, including preterm-births and low birth weight.¹⁴ In 2013-14, there were 63,456 potentially preventable hospital separations related to dental conditions.¹⁵

¹⁴ Australian Government Department of Health. 2012. Final Report of the National Advisory Council on Dental Health.

¹⁵ AIHW: Chrisopoulos S, Harford JE and Ellershaw A. 2016. Oral health and dental care in Australia: key facts and figures 2015. Cat. no. DEN 229. Canberra: AIHW.

Oral conditions are the second most expensive disease group to treat in Australia. Unlike other health services, the cost of oral health largely falls on the individual resulting in significant unmet need. In 2014–15 individuals were responsible for 57.7 per cent of the total cost of dental care compared to only 16.3 per cent of the cost of all other health services.¹⁶

The 2014–15 Budget cut \$650 million from dental programs across the forward estimates, in addition to expenditure cuts of \$42.4 million made in the 2013–14 MYEFO.¹⁷ In the 2015–16 Budget, further measures relating to dental health were introduced with a reduction in expenditure of \$125.6 million across the forward estimates from the Child Dental Benefits Schedule, in addition to reduced expenditure on dental workforce programs and payments to Department of Veterans' Affairs dental health providers. This Budget also removed funding in the forward estimates for adult public dental services.¹⁸

On 15 December 2016, the Minister for Health and Aged Care announced funding cuts for public dental services as of 1 January 2017.¹⁹ Public dental services are set to be severely compromised as a result of the Commonwealth Government's reduction in funding for public dental health services for the next three years.

While the Minister announced the National Partnership Agreement for public dental services to adults will continue to receive Federal funding of \$320 million over this year and the next two years (or less than \$107 million per year for the next three years), this is a reduction from the Minister's announcement of about \$155 million in calendar year 2016. The original Budget measure in 2013–14 promised \$391 million in 2016–17. This will result in as many as 338,000 Australians losing access to timely and affordable care.

The Government's decision to reduce federal funding to the states and territories for the provision of essential dental services to the most vulnerable in the community means that wait times at public dental clinics, which are already running into years, will only get longer and leave more patients at risk. These changes will negatively impact Australians least able to afford proper dental care.

¹⁶ AIHW (2016a) *op cit*.

¹⁷ Russel, L. 2014. Analysis of 2014–15 health budget: unfair and unhealthy, Menzies Centre for Health Policy, University of Sydney.

¹⁸ Commonwealth of Australia. 2015. Budget 2015–16: Budget Paper No. 2. Commonwealth of Australia.

¹⁹ Minister for Health and Aged Care the Hon Sussan Ley. Media release: Continued funding for states from 1 January 2017. 15 Dec 2016. Available at: [http://www.health.gov.au/internet/ministers/publishing.nsf/Content/DDA645B010401EB7CA25808A000BA829/\\$File/SL108.pdf](http://www.health.gov.au/internet/ministers/publishing.nsf/Content/DDA645B010401EB7CA25808A000BA829/$File/SL108.pdf).

7 Better use of medicines and treatments

Key Recommendations:

- Continue the Medicare Benefits Schedule Review currently underway, and link in with work separately being undertaken by the Commonwealth funded National Prescribing Service (NPS) on the Choosing Wisely initiative.
- Ensure alignment of NPS work in promoting evidence-based use of medicines and treatments with the Primary Health Network roles in developing regional health pathways and supporting capability development in general practice.

National Prescribing Service (NPS) Medicine Wise is funded by the Commonwealth Government through the Department of Health, and the work it is undertaking on the Choosing Wisely initiative should be linked to and inform the MBS Review currently underway.

Primary Health Networks (PHNs) have been charged with developing and supporting evidence-based health pathways, capacity development in general practice, and data collection and analysis to inform the planning and provision of health services. NPS Medicine Wise leads national work on better use of medicines. National coordination by the Department of Health is required to address the lack of a shared policy agenda and duplication of effort, in addition to ensuring consistency and collaboration in working with general practice at regional levels.

PHNs have the key role as regional coordinators and commissioners of primary health services, including capacity development in general practice and assessment of regional health needs to determine health priorities. NPS Medicine Wise works with consumers and health professionals to improve the way medicines and medical tests are used, including via education programs delivered to general practice. The following should be implemented to ensure the alignment of related activities:

- Working arrangements between NPS Medicine Wise and PHNs should be nationally-coordinated via the Department of Health to ensure policy coherence and a coordinated approach to program delivery. This should include consideration of roles and responsibilities for regional delivery of education and communications programs to general practice, data development, collection and access, and associated costs.
- This work should be conducted in formal partnership with PHNs at the regional level, based on a shared policy agenda, and coordinated by the Department of Health, with regular briefings provided back to PHNs.
- Best practice data governance practice based on the principle of ‘collect once, use many times’ should be implemented. Multiple agencies collecting data from general practice is an inefficient approach and does not engender positive relationships. PHNs should also have a role in regional primary health data governance.
- Data currently collected by NPS Medicine Wise on prescribing patterns has value for regional health needs assessments but is not readily accessible and should be customised to align with PHN priorities. Data development, access and costs should be determined with due consideration to the Commonwealth’s health policy agenda and funding for this work.

These proposals should be funded from existing resources.

8 Pharmaceuticals and pharmacy

Key Recommendation:

- Reform in the pharmaceutical and pharmacy sector must be considered as part of a coordinated approach to achieving the objectives of the National Medicines Policy.
- Invest in the development of a health workforce strategy to ensure that pharmacists (along with all the health workforce) are utilised to the full scope of their professional expertise.

The National Commission of Audit reported that fundamental reforms to the PBS and the pharmacy sector are needed to drive innovation and competition, increase consumer choice and contain costs to the Commonwealth.²⁰ It reports that ongoing yet incremental improvements are not enough if the cost drivers are to be effectively and fairly addressed. The Government currently has a number of review processes underway that will inform reform. The more prominent of these include:

- Reform of Regulation of Medicines and Medical Devices
- Review of Pharmacy Remuneration and Regulation

Reform in the pharmaceutical and pharmacy sector must not be considered in isolation – it must be part of a coordinated approach to achieving the objectives of the National Medicines Policy²¹, across the primary, acute, aged care and disability sectors. There are opportunities to implement a range of measures to achieve efficiency within the sector without impacting on quality of care for patients.

These include:

- Reviewing existing Pharmaceutical Benefits Schedule (PBS) products for their continued appropriateness and efficient cost as research and development in pharmaceutical ‘technology’ continues to advance. The PBS program needs to reflect developments in the pharmaceutical sector, while at the same time provide value for money on the investment of health dollars being made.
- Using the negotiating power of the Commonwealth more effectively to purchase pharmaceuticals at more competitive prices. For example, it has been shown that Western Australia and one other Australian state were able to purchase pharmaceuticals at prices significantly less than the PBS which paid an estimated additional \$750 million²².
- Pursuing further efficiencies through the continuation of price disclosure mechanisms and increasing consumer confidence in and use of generic medicines.
- Implementing the recommendations from the Review of Pharmacy Remuneration and Regulation to ensure quality health outcomes are delivered through community pharmacy, access and quality use of medicines are promoted, and there is recognition of the contribution of pharmacists and pharmacy in the broader Australian healthcare sector.
- Ensuring that pharmacists are utilised to the full scope of their professional expertise, allowing innovation in the provision of health services across the health, aged care and disability sectors.

The AHHA supports a performance and reporting structure focusing on outcomes, rather than throughput, through the development of indicators, which could then be tied to outcomes based funding when more timely and robust data collection and dissemination is in place to enable such a change. This performance and reporting structure should also be consistent across services (e.g.

²⁰ National Commission of Audit. 2014. Towards Responsible Government - The Report of the National Commission of Audit. Commonwealth of Australia.

²¹ National Medicines Policy Document. Available at: <http://www.health.gov.au/internet/main/publishing.nsf/content/national-medicines-policy>.

²² Duckett, SJ with Breadon, P, Ginnivan, L and Venkataraman, P. 2013. Australia’s bad drug deal: high pharmaceutical prices. Grattan Institute, Melbourne.

general practice, pharmacy, allied health, community health services) to enable comparisons to be made of innovations in scopes of practice and role substitution.

9 Private health insurance

Key Recommendation:

- The Commonwealth Government advance its review of private health insurance proposing reforms to ensure:
 - Simpler products;
 - Better communication with policy holders;
 - Removal or better application of the private health insurance rebate to safe and effective evidence-based treatments;
 - Policies which meet consumer need;
 - Better business practices;
 - Equity and accessibility assurance for the non-insured;
 - The right of privately-insured hospital patients to choose their own doctor, whether in a private or public hospital; and
 - Continued ability to use private insurance in public hospitals.
- The Government's current consideration of mandating simplified health insurance policies to gold, silver and bronze must ensure that the bronze category, its lowest cost category, does not discriminate against women, people with chronic disease or disadvantaged population groups by excluding coverage of particular services.
- The Commonwealth Government must ensure its reform process undertakes broad consultation across both the public and private sectors.

Australians have expressed concerns about the complexity of private health insurance products and the lack of clear information provided by insurers. Private health insurance arrangements must support equity, accessibility and sustainability of the broader Australian health system to benefit the whole community.

The Australian Competition and Consumer Commission's 2016 report on anti-competitive and other practices by health insurers and providers observes that private health insurance policies are complex and do not readily support comparisons, accurate assessments of costs and, in some cases, may include possible misrepresentations of products and their value.²³

In 2014–15 the Australian Government spent \$5.8 billion on the Private Health Insurance Rebate, given directly to private health insurance funds and meant to assist Australians meet the cost of private health insurance.²⁴ But there is international evidence that the cost of subsidising private health insurance exceeds the fiscal benefits to the public sector.^{25,26}

These funds should be reallocated to parts of the healthcare system in greater need. Any savings from the abolition or scaling back of the private health insurance rebate must be transparently

²³ Australian Competition and Consumer Commission. 2016. Communicating changes to private health insurance benefits: a report to the Australian Senate on anti-competitive and other practices by health insurers and providers in relation to private health insurance for the period 1 July 2014 to 30 June 2015. Available at: https://www.accc.gov.au/system/files/1109_Private%20Health%20Report%202014-15_FA1_web.pdf.

²⁴ Expenditure on the Rebate in 2015-16 is estimated to be \$5,953.4 million (refer to Portfolio Budget Statements 2016-17, Budget Related Paper No. 1.10, Health Portfolio. Commonwealth of Australia, 2016).

²⁵ Cheng TC. 2013. Does reducing rebates for private health insurance generate cost savings? Melbourne Institute Policy Briefs Series, Policy Brief No. 3/13.

²⁶ Daley J. 2013. Balancing budgets: tough choices we need. Grattan Institute, Melbourne. p. 71.

redirected to public health system funding, including broadening the list of items covered by the Medicare Benefits Schedule.

Budget 2016–17 announced the establishment of a Private Health Ministerial Advisory Committee with funding for three years to provide advice on the design and implementation of private health insurance reforms. AHHA commends the Government as it works toward developing proposed new arrangements for private health insurance aimed at improving value and transparency of information for consumers.

These reforms need to ensure:

- simpler products
- better communication with policy holders
- removal or better application of the private health insurance rebate to safe and effective evidence-based treatments
- policies which meet consumer need
- better business practices
- equity and accessibility assurance for the non-insured
- the right of privately-insured hospital patients to choose their own doctor, whether in a private or public hospital
- continued ability to use private insurance in public hospitals

This will lead to better value policies which increase the use of the private health system and more informed consumer choice.

The Government's current consideration of mandating simplified health insurance policies to gold, silver and bronze categories must ensure that the bronze category, its lowest cost category, does not discriminate against: women, for example by excluding obstetrics; people with chronic disease, for example by excluding some cardiac care services; or disadvantaged population groups, for example by excluding coverage for appropriate mental health services.

Any reforms relating to private health insurance require broad consultation across the public and private sectors with community support.

10 Preventive healthcare

Key Recommendation:

- The Government must prioritise developing and implementing preventive health strategies. These strategies should direct attention to overweight and obesity, alcohol misuse and abuse, tobacco consumption, inequality and immunisation.
- Funding for preventive health should be increased to at least 2.3 per cent of recurrent health spending, with a proportion of this quarantined for expenditure through Primary Health Networks for locally targeted initiatives responding to areas of community need.
- Investment is needed in a broad array of evidenced-based strategies to discourage the consumption of sugar-sweetened beverages. This multifaceted approach should include:
 - Measures to regulate availability
 - Improving labelling
 - Restricting promotion
 - Reducing consumption
 - Increasing public awareness of the potential harm
 - Implementing a 20 per cent ad valorem sugar-sweetened beverages tax.
- Revenue raised from a sugar-sweetened beverages tax should be hypothecated for preventive health measures.

The Government must prioritise developing and implementing preventive health strategies. While investing in preventive health measures generates a short term cost, innovative initiatives can also create savings in reduced health care costs in the future. With the fourth Intergenerational Report highlighting the pressure that health costs will place on the Commonwealth budget, it is vital that preventive health strategies be encouraged to lessen the individual, intergenerational and health system burden, improve health system resource use and boost productivity through greater economic participation and productivity. Australia's Health 2016 reports that 31 per cent of Australia's burden of disease is preventable, intensifying the need for investment in evidence-based preventive health strategies.

Australia spends less on public health and prevention than most other OECD countries, ranked fourth lowest in 2013 with 1.9 per cent of recurrent health spending, compared with Canada's 6.1 per cent and the United Kingdom's 4.1 per cent.²⁷ Since peaking at 2.3 per cent in 2007–08, spending has fallen to 1.6 per cent in 2014–15.²⁸

Through participation in the World Health Organisation, Australia has committed to reducing premature mortality from the four major non-communicable diseases by 2025. These are cardiovascular disease, cancer, chronic lung diseases and diabetes. Hospital services accounts for around 40 per cent of health expenditure in Australia. Investment in effective prevention efforts and primary health care programs aimed at addressing these four disease groups will support reduction in hospitalisations, leading to lower hospital expenditure.

Health policy today will have a tangible impact on the problems faced by the health system in the future. With the Commonwealth, state and territory governments facing budgetary pressure from rising health costs, an effective way to in part address concerns about future budget pressures is to

²⁷ OECD.Stat. Organisation for Economic Co-operation and Development. Available at: <http://stats.oecd.org/index.aspx?Dataset> Code=SHA (accessed 16 January 2017).

²⁸ AIHW (2016a) *op cit*.

take earlier steps to prevent health conditions from occurring, delaying the onset and reducing the severity of any conditions. Preventive health is an important means of reducing future demand on the health system while simultaneously improving quality of life for all Australians. Investing in preventive health measures is a low cost way of reducing this future fiscal pressure while also improving the wellbeing of all Australians.

Expenditure on preventive health measures can legitimately be viewed as contributing to fiscal repair by reducing future demand on the health system while simultaneously improving health outcomes for all Australians. Expenditure should be increased to at least 2.3 per cent of recurrent health spending, with a proportion of this quarantined for expenditure through Primary Health Networks (PHNs) for locally targeted initiatives responding to areas of community need.

Priority areas of focus in preventive health should include:

- Overweight and obesity
- Alcohol misuse and abuse
- Tobacco control
- Inequality
- Immunisation

Obesity is an Australian health priority with the 2015 Global Burden of Disease study showing that obesity has taken over from smoking as the leading cause of preventable death or illness in Australia. 63 per cent of the adult population are now overweight or obese, up around two-thirds from 38 per cent in 1989–90. Increased consumption of energy-dense nutrient-poor foods is the predominant cause with estimates that sugar-sweetened beverages (SSBs) account for at least one-fifth of weight gain. Obesity has high economic and human consequences at an individual and societal level. Australian modelling shows that the direct health costs of obesity in 2011–12 were \$3.8 billion²⁹.

Investment is needed in a broad array of evidenced-based strategies to discourage the consumption of SSBs, to incrementally reduce overweight and obesity and improve health outcomes. This multifaceted approach should include measures to regulate availability, improve labelling, restrict promotion, reduce consumption and increase public awareness of the potential harm, for example:

- Taxation of SSBs to improve population diet and reduce consumption of SSBs, resulting in a meaningful reduction in obesity and rates of chronic disease.
- Restrictions on the sale of SSBs in public institutions such as hospitals and schools.
- Strengthened advertising restrictions for SSBs, particularly during children's television viewing times.
- Mandatory interpretive front-of-package labelling of SSBs.
- Public awareness campaigns to ensure consumer awareness of health risks associated with SSBs.

Increasing the price of SSBs through taxation will reduce consumption, particularly for younger Australians. While this is likely to have a modest impact on population rates of obesity it will result in substantial benefits to population health. An additional 20 per cent ad valorem tax will reduce rates of type 2 diabetes, heart disease and stroke, with an estimated 1,600 extra people alive after 25 years as a result of the tax, providing considerable health system savings and generating an estimated \$400 million in revenue annually.³⁰

²⁹ PwC 2015, *Weighing the cost of obesity: A case for action*. Obesity Australia, PwC.

³⁰ Veerman JL, Sacks G, Antonopoluos N and Martin J. 2016. The impact of a tax on sugar-sweetened beverages on health and health care costs: A modelling study. *PLoS ONE*, 11(4), 1-10.

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

11 Control of rheumatic heart disease in Aboriginal and Torres Strait Islander Peoples

Key Recommendations:

- Case management of people with acute rheumatic fever and their families involving both clinical and social assessments.
- Support for secondary prophylaxis outreach to provide regular antibiotic injections.
- A national register for rheumatic heart disease.

Despite rheumatic heart disease (RHD) being very rare in Australia, the disease is endemic in rural Aboriginal and Torres Strait Islander communities.³¹ After adjusting for differing population age structures, Indigenous Australians in the Northern Territory are 39 times more likely to live with RHD than non-Indigenous Australians, while in Queensland this rate is 206.³² Aboriginal and Torres Strait Islander peoples have one of the highest prevalence rates of RHD in the world and almost exclusively account for all newly identified cases in Australia.³³

While there is currently a review of the National Rheumatic Fever Strategy underway, it is vital that efforts to control this disease are continued. In the interim AHHA calls for the following measures to be funded to enhance Australia's ability to control the disease. These would build on the existing jurisdictional control programs and the work of the National Coordination Unit for RHD.

AHHA recommends case management of people with acute rheumatic fever and their families involving both clinical and social assessments. All people with acute rheumatic fever, whether a primary or recurrent episode, should have a comprehensive clinical and social assessment to plan their care over the following decade.

AHHA recommends support for secondary prophylaxis outreach to provide regular antibiotic injections. Outreach services are needed to deliver antibiotic injections every four weeks to prevent recurrences of acute rheumatic fever. This would also provide the opportunity for other primary care services to be delivered at these visits including management or referral for trachoma, chronic ear disease, skin infections and respiratory illness for people with RHD and their families.

AHHA recommends support for a national register for rheumatic heart disease. While there are existing jurisdictional RHD registers, a national register would enable integrated health care delivery for patients who are away from, their usual place of treatment. A national register for RHD would be a valuable tool for continuous quality improvement, in addition to the analysis of outcomes and progress in acute rheumatic fever and RHD prevention and control at national, jurisdictional and sub-jurisdictional levels.

³¹ Wyber R. 2014. Indigenous Australia left behind in rheumatic heart disease fight. *The Conversation*. Available at: <http://theconversation.com/indigenous-australia-left-behind-in-rheumatic-heart-disease-fight-24346>.

³² Australian Health Ministers' Advisory Council (AHMAC). 2015. *Aboriginal and Torres Strait Islander Health Performance Framework 2014 Report*. AHMAC, Canberra.

³³ Gray C and Thomson N. 2013. Review of acute rheumatic fever and rheumatic heart disease among Indigenous Australians. *Australian Indigenous Health Bulletin*. 13(4), pp 1-14.

12 End of life planning

Key Recommendations:

- A nationally consistent legislative framework to support end-of-life decision-making.
- Enhanced integration of advance care planning documents in My Health Record with primary, hospital and community health IT systems.
- System-wide transformation of palliative care services and models of care to better respond to end-of-life needs and to meet increasing demand. These changes will require a coordinated and integrated approach across primary, community, specialist and hospital care.
- An MBS item to support the central involvement of GPs in end-of-life planning.
- End-of-life planning is included in the accreditation and quality framework.

Australians are living longer, with the number of deaths in Australia set to double over the next 25 years.³⁴ End-of-life (EOL) care should relieve suffering, preserve dignity, be accessible and enable people to die in a place of their choice. The health system in Australia today provides increasingly aggressive therapies for the frail elderly that often extend life but also have the potential to cause harm. As a nation we have been slow to adapt to the care requirements of the increasing prevalence of chronic diseases and an aging population. Palliative care services have inadequate capacity to provide consistent and coordinated care for current or future needs for EOL care.

Benefits and considerations include:

- AHHA recognises that balancing health care expectations with the resource-constrained health system to provide satisfactory EOL care is challenging. While hospitalisation at EOL is common, with improved EOL discussions and a planned approach it is possible to firstly improve care by reducing hospitalisations and unwanted and often invasive life prolonging treatment, and secondly to reduce their associated costs by providing access to less acute inpatient palliative or hospice care.³⁵
- AHHA supports the Senate Community Affairs Reference Committee recommendation to harmonise laws across all jurisdictions about advance care planning documents and substitute decision-makers.³⁶ This will support a nationally consistent approach that will protect clinicians from medico-legal risk and provide a decision making framework to move patients to non-acute and palliative services.
- My Health Record accepts uploads of advance care planning documents. However, access to these documents should be enhanced, with greater linkage and alerts to the existence of these documents in primary health, hospital and community IT systems. This will facilitate continuity and coordination of care, improve clinician awareness and assist in providing care that aligns with advance care planning decisions. Additionally, such systems could potentially prompt discussion and documentation of advance care planning at key times in the patient journey:
 - At agreed milestones (such as 75+ health assessments)
 - During chronic disease planning and with the development of multiple comorbidities

³⁴ Swerissen H and Duckett S. 2014. Dying well. Grattan Institute, Melbourne.

³⁵ McCarthy IM, Robinson C, Huq S, Philastre M and Fine RL. 2015. Cost savings from palliative care teams and guidance for a financially viable palliative care program. Health Services Research, vol. 50, no. 1, pp. 217-236.

³⁶ Community Affairs Reference Committee (CARC). 2012. Palliative care in Australia. Community Affairs References Committee, The Senate. Commonwealth of Australia, Canberra.

- At onset of dementia
- EOL planning would benefit from continued research into new strategies to improve this area of care, such as improved clinical capacity to reliably predict people approaching the end of life in the short to medium term. The creation of new interventions for management of pain and other symptoms, and investment for the development of health technologies will also better support high quality EOL care.
- Education campaigns about EOL care options for medical professionals and public awareness programs that promote and support EOL conversations and care will ensure that it is both aligned with the desires of the patient and enables all members of the health and care team to provide the right care.
- An MBS item should be established that supports the central involvement of GPs in end of life planning. This plan could be linked into a patient's My Health Record which would support care being provided that aligns with the wishes and needs of the patient, regardless of what part of the health system they access. Such an MBS item could form part of a set of linked items on chronic disease management and integrated care.
- Requirements for EOL planning should be included in relevant aged care facilities and services, and national health accreditation and quality standards.

Better EOL planning has the potential to improve patient outcomes while also providing savings to the health system. With an ageing population, this proposal is a sensible approach towards the dignified treatment of elderly Australians, chronic disease sufferers and for the health and aged care systems.

13 Social impact investing

Key Recommendations:

- The Commonwealth Government work with state and territory health departments and Primary Health Networks to pilot small scale social impact investing initiatives tied with research components to establish an Australian evidence base on the effectiveness of this novel financing model.

Using social impact investing to drive positive health outcomes for specific conditions or populations is in its infancy in Australia. But governments, such as New South Wales among others, are beginning to look at the international evidence and considering how social impact investing could be used in Australia to drive outcome-focused improvements.

Social impact investing involves private investors funding outcome-focused interventions and governments paying back the principal as well as a return on the investment only once the program meets its agreed outcomes. The attractiveness of social impact investing lies in risk mitigation to governments, cash flow management for government departments and the potential to promote innovation and increase accountability in service delivery through public-private partnerships.

Impact investing in health would require a change in mindset away from discussions of whether private or public interests are responsible for treating ill-health. The focus shifts to the mitigation of ill-health by adjusting tastes and behaviours and the achievement of positive health outcomes.

Essential ingredients for success in pursuing impact investing in the health sector include the development of measurable and robust outcomes, niche investors seeking a return on a public good, the development of effective and innovative interventions, and consensus among the parties throughout the journey.

Working together, Primary Health Networks (PHNs) and Local Hospital Districts (LHDs) or their equivalent are well-placed to be agents of positive change in realising better population health outcomes while being prudent fiscal stewards of public funds.

PHNs and LHDs have an opportunity to engage in impact investments in order to respond more directly to local needs. A funded emphasis on better health outcomes rather than simply focusing on payments based on activity is consistent with the commissioning role envisaged for the PHNs.

More work is needed to determine the applicability of social impact investing to the Australian primary and acute healthcare environment. The Commonwealth Government should work with state and territory health departments to pilot small scale social impact investing initiatives tied with research components to establish an Australian evidence base on the effectiveness of this novel financing model.

14 Unlegislated measures carried forward in the budget estimates

Key Recommendation:

- Pharmaceutical Benefits Scheme and Medicare measures announced in the 2014-15 Budget that have not been legislated but remain in the forward estimates should be removed.

The Parliamentary Budget Office has reported on measures that have been announced by the Government, have not been legislated but remain in the forward estimates.³⁷ Two of these measures relate to co-payments and safety net thresholds applying to the Pharmaceutical Benefits Scheme and Medicare safety net arrangements that were both announced in the 2014-15 Budget.

Were these measures enacted, they would increase inequality and out-of-pocket expenses. AHHA calls on the Government to remove these measures from the forward estimates given the three year period that has elapsed once the coming Budget is delivered.

There will be no cost to the Budget from removing these measures as the savings realised were to be directed to the Medical Research Future Fund.

³⁷ Parliamentary Budget Office. 2016. Unlegislated measures carried forward in the budget estimates - June 2016 update. Parliament of Australia.

Conclusion

A high quality healthcare system is key to a healthy population and a strong economy, and Australia is fortunate to have such a system, delivering world-class health outcomes for many Australians. But this overall strong result also masks many pockets of health inequality in Australian society. There is also the need to use the resources that are made available to the health system as effectively and efficiently as possible.

AHHA is encouraged by some of the more recent developments in the healthcare field such as the pending trials of the Health Care Homes, the 2016 COAG agreement on public hospital funding and the apparently successful My Health Record opt-out trial. But initiatives in these and other areas must be appropriately resourced to ensure the health objectives can be met.

The latest health expenditure statistics show that 2014-15 was the third year in a row of below-average growth in spending on health and continued a seven year decline in the share of total health expenditure funded by the Australian Government. The share of health expenditure from non-government sources continues to grow.³⁸

Leadership in the field of health needs to represent more than just financial cuts over a four year planning horizon. The 2017-18 Budget must instead present effective solutions that compromise neither the short term nor long term health of Australians or our health system. By implementing sensible changes in health policy, more can be achieved with our existing health system without having to commit additional resources.

Most of the recommended budget measures and policy directions presented in this submission do not seek new or additional funding, but rather propose to more sensibly target and organise the existing health infrastructure Australia has in place. They also emphasise the need for better coordination across primary, acute, aged and disability care sectors with both the efficiencies and better patient outcomes this can produce.

³⁸ AIHW (2016a) *op cit.*



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