The Hon Josh Frydenberg MP
Treasurer
Parliament House
CANBERRA ACT 2600

Dear Treasurer,

Catholic Health Australia (CHA) is Australia's largest non-government grouping of health, community, and aged care services accounting for around 15 per cent of hospital-based healthcare in Australia. Our members also provide around 30 per cent of private hospital care, 5 per cent of public hospital care, 12 per cent of aged care facilities, and 20 per cent of home care and support for the elderly. CHA not-for-profit providers promote the ministry of health care as an integral element of the mission and work to fully provide health care to the sick, the aged and the dying. This ministry is founded on the dignity of the human person, giving preference to the needy, suffering and disadvantaged.

While Australia is consistently recognized as one of the best health systems in the world when it comes to health outcomes, there are growing concerns about the sustainability and efficiency of this system into the future. Factors such as income, geography, disability, and indigenous status impact upon how individuals access and benefit from health services.[1]

With a steady decline in wage growth[2], increasing cost of living constraints, and the rising cost of healthcare are putting critical pressure on the health system. As out-of-pocket health costs have soared, Australians have sought to access more services through the public health system or delayed receiving services or filling prescriptions because of the cost.[3] This current trajectory undermines the universality of Medicare and reduces the efficiency of our health system.

In this pre-budget submission, CHA have focused on three key policy areas where we believe that access and equity in healthcare still requires better funding and policy reform to meet the unmet health demands of Australians.

- Enhance the value proposition of private health insurance,
- Better resourcing for end-of-life care and palliative care services,
- Equity in health outcomes for vulnerable populations.

[1] Australian Institute of Health and Welfare. *Australia's health 2018: in brief*. AIHW, 2018.
[2] Gilfillan, Geoff (2019). The extend and causes of the wage growth slowdown in Australia. Australian Parliament, pp.1-27.
[3] Patient Experiences In Australia: Summary Of Findings, 2018-19. Australian Bureau Of Statistics, Canberra, 2019, https://www.abs.gov.au/ausstats/abs@.nsf/mf/4839

Recommended Budget Priorities:

1. Preserve community rating as an essential component of access to private health insurance.
2. Reduce the risks to patients associated with vertical integration, or operators who are both providers and funders of services. Ensure safety and quality standards are equivalent across hospitals substitute services and establish a required minimum benefit for out of hospital care.
3. Review the modelling of lifetime health cover and household umbrella policies to determine whether the regulatory reforms that were originally enacted to encourage the uptake of private health insurance are now acting as disincentives to participation.
4. Reinstate the 30% rebate for low-income families.
5. Double the Medicare levy surcharge for high income earners.
6. Government should endorse guidelines ensuring minimum quality standards.
7. Government should introduce a minimum default benefit to hospital-based alternative models that reduce risk of hospitalisation and avoidable readmission.
8. Task IHPA with developing coding standards for end-of-life care and palliative care to better capture data around the delivery of services in the acute setting to understand the scope of need and target future resources.
9. Review a Medicare rebate for medical services provided for palliative care activity that accounts for holistic multidisciplinary care. Also establish Medicare rebates for palliative care telehealth services delivered by nurse practitioners.
10. Given the number of people who would prefer not to spend their last days in a hospital, set a national target that facilitates an increase in the number of people dying in their place of choice (whether that be at home or in a residential facility).
11. Strengthen community palliative care models by funding new evidenced-based palliative specialist models, such as those which work with aged care facilities to identify those with palliative care needs and develops pathways to better manage their end-of-life care and reduce hospitalisations.
12. Expand palliative care education across the medical disciplines and elevate the conversation to improve palliative care awareness by the public.
13. Continue to shift the focus of the system from crisis and acute care to community-based services, primary health care, prevention and early intervention, including increased access to community-based supports following discharge from hospital, particularly for those at high risk of suicide.
14. Continue to move towards a single source of funding for all mental health services, thereby removing existing barriers (multiple systems with little integration) to efficient service delivery.
15. Improve the capability and capacity of Primary Health Network (PHN) commissioning processes for the delivery of local mental health services, including joint commissioning of services between PHNs, Local Health Districts/Areas (LHDs/LHAs) and Private Hospitals, where appropriate.
16. Improve funding and access to health services to meet the needs of asylum seekers, including greater transparency in the quality and delivery of care received.
17. Establish greater workforce and infrastructure supports for regional hospitals to ensure the skills and capital investments for quality and innovation available to urban communities are also available to regional communities.

Private Health Insurance Value Proposition

CHA strongly supports the consideration of reforms for the private health insurance (PHI) industry with the goal of making policies affordable, retaining value of products, reducing out of pocket costs (OOPs), and providing much-needed stability to the sector. CHA believes that there is an urgent need for the Government to increase accountability, transparency, and reduce waste in the healthcare system as a responsible steward of Australian taxpayer dollars.

Due to the administrative overheads of funding arrangements (including audits and risk and reporting), the health sector needs to account for how much of every dollar is spent directly on patient care. There are a range of administrative functions that can prove costly and convoluted and take away from direct patient care. Ways to make the system more efficient need to be examined.

We have listed some principles that we would like to see reflected in further reforms:

Community Rating

CHA strongly supports retaining community rating for PHI.

Retaining the community rating is essential to providing universal access for all, one of the founding principles that applies to healthcare in Australia through Medicare. However, there are a number of issues which impact on the viability of community rating. This includes the proliferation of lower premium products in order to attract consumers that creates a bigger cost impost on those with fully comprehensive products, thus distorting the community rating principle.

Improvements can be made that support maintaining the principle of community rating such as alternative funding models, reinstating the rebate for lower income households, and regulating the proliferation of policies with restrictions and exclusions.

Relief for Young People and Low Income Families

Economic pressures are contributing toward people living at home for much longer, getting married later, and starting families in their 30s. Wage stagnation for young people and economic pressures mean young people are reconsidering the need for PHI.

APRA data shows that around 7000 people aged between 25 and 29 cancelled their policies in the last quarter alone.[4] With the current trend, that's close to 30,000 people, largely in their mid to late 20s, cancelling PHI.

In order to incentivize young people to take up and maintain their PHI, we encourage the Government to consider increasing the age young people can stay on their parents policy from the current 25 to 30. Furthermore, the capacity to stay under the household umbrella should be expanded. Some current policies are so restrictive that only people who are unmarried and making under $20,000 can take remain on their family policies, meaning many young people are being forced out to make their own health insurance choices from the age of 21[5]. Raising the parental policy age to 30 would plug a critical

[4] Quarterly Private Health Insurance Statistics, September 2019. Australian Prudential Regulation Authority, 2019, https://www.apra.gov.au/sites/default/files/Quarterly%20Private%20Health%20Insurance%20Statistics%20September%202019.pdf. Accessed 3 Feb 2020.

[5] Wood, D., Griffiths, K., and Emslie, O. (2019). Generation gap: ensuring a fair go for younger Australians. Grattan Institute.

gap in which young people drop off their family plans, get used to life without insurance in their 20s, and become reluctant to pick it back up again.

Reviewing the age at which the lifetime health cover (LHC) penalties take effect would also encourage young adults to consider PHI coverage. Maternity services involve a significant cost to young adults and are one of the few medical conditions that people can plan for. Review of the LHC should take into account the fact that women are having children later in life than they were 20 years ago when these regulations were first enacted. Currently, LHC adds an extra 2% to yearly premiums for anyone aged over 30 who decides to take out hospital cover later on. Therefore, those who are 34 when deciding to have a baby and wish to access the private system are faced with signing up to an additional 8% a year LHC on top of their gold-level health insurance premiums. When starting a family, this extra financial burden could very easily be putting women off from taking out insurance and pushing them into the public sector.[6] Raising the age of LHC to 35 years could help solve this and better reflect our changing society.

While the industry weighted average for 2020 premium increases was 2.92 percent, it is important to note that the average premium increases published annually PHI products does not apply equally across all funds or all product tiers. The premium increase applied to comprehensive products is much higher than the increasing premium on basic policies, however it is reported as an average of all products which decreases transparency for consumers.

This means that families who want more comprehensive cover are likely to see higher premium increases than those with basic products which contain more restrictions and exclusions.

Indexing the PHI rebate to the Consumer Price Index has meant that the real value of the rebate for households on low incomes has been reduced from 30 percent to under 25 percent as premium increases continue to exceed general inflation.[7] A decreasing rebate and rising premiums are resulting in falling participation or downgrading cover in PHI. This leads to further pressure and reliance on the public health system that is already experiencing higher than normal wait lists.

Reinstating the 30 percent rebate for the lowest income tier (Individuals making less than $90,000, or families less than $180,000) would provide much needed relief to the cost pressures facing an increasing number of families and encourage the uptake of policies, in turn relieving some of the pressure on the public system. The cost of reinstating the rebate could be offset by doubling the Medicare Levy Surcharge for the highest income earners and serve as a more realistic incentive to higher income households to invest in PHI.

Improved Models of Care Out of Hospital

CHA hospital providers offer a range of out-of-hospital models designed to deliver quality healthcare in the right setting at the right time. These patient-centred programs seek to provide greater options for patients to receive services designed to address their individual needs, reduce complications related to hospital admission, and prevent avoidable hospital readmissions.

[6] Khadem, Nassim. "'Waste of Money': Women Ditch Private Hospitals, Go Public to Give Birth." The Sydney Morning Herald, The Sydney Morning Herald, 27 June 2018, www.smh.com.au/business/consumer-affairs/waste-of-money-women-ditch-private-hospitals-go-public-to-give-birth-20180627-p4zo3q.html.
[7] "PHI 7/20 Private Health Insurance – Rebate Adjustment Factor Effective 1 April 2020." Department of Health, 30 Jan. 2020, www1.health.gov.au/internet/main/publishing.nsf/Content/health-phicircular2020-07.

The Private Health Insurance Act currently allows for non-hospital providers to receive benefits for 'hospital substitute treatment', that is general treatment that substitutes for an episode of hospital treatment. Many health fund are currently providing hospital substitute services, serving as funder and provider of these services. Consumers should have the assurance that these services they receive are equivalent in safety and quality as those services they would receive from hospitals.

Hospitals are required to meet National Safety and Quality Health Services standards for accreditation, as well as meet the requirements of clinically agreed guidelines by industry bodies across disciplines. These guidelines have served as the industry agreed standards for healthcare in the hospital provider setting and should be endorsed by Government to ensure minimum quality standards are adhered to by all service providers.

Current regulatory requirements already recognise that hospital services can include programs delivered by the hospital in a community or home-based model. While claims by health funds have long posited that regulatory barriers are the greatest impediment to providing services out of hospital, health providers contend that it is lack of support from private health insurers to extend hospital-based services into the home and community.

Without minimum default benefits for hospital based home and community care services, only health funds who contract with providers to deliver programs are able to offer them. Even when evidence-based programs are established, health funds can refuse to contract with the hospital for those services. This impacts the sustainability and flexibility of innovation in the ability to deliver alternative models. Establishing a minimum default benefit for out of hospital care would enable hospitals to develop and sustain these programs and reduce the associated costs and risks of hospital readmissions.

<u>Recommended Budget Priorities:</u>

1. Preserve community rating as an essential component of access to PHI.
2. Reduce the risks to patients associated with vertical integration, or operators who are both providers and funders of services. Ensure safety and quality standards are equivalent across hospitals substitute services.
3. Review the modelling of LHC and household umbrella policies to determine whether the regulatory reforms that were originally enacted to encourage the uptake of PHI are now acting as disincentives to participation.
4. Reinstate the 30% rebate for low income families.
5. Double the Medicare levy surcharge for high income earners.
6. Government should endorse guidelines ensuring minimum quality standards
7. Government should introduce a minimum default benefit to hospital-based alternative models that reduce risk of hospitalisation and avoidable readmission.

Better resourcing for end-of-life care and palliative care services

More Australians will need end-of-life care (EOLC) including palliative care (PC) in the coming years than ever before, with demand for palliative care services predicted to increase dramatically over the coming decades. By 2056, those aged over 65 will increase from 15 percent to 22 percent and the proportion

of people aged over 85 will double. As a result of this ageing population and high rates of chronic disease, the number of deaths is increasing and is predicted to more than double by 2061.[8]

CHA members form a national network of over 80 hospitals, more than 25,000 aged care residential beds and numerous community care organisations. CHA members provide 13 per cent of all PC-related hospitalisations in Australia. In the private sector, CHA members make up the majority of PC inpatient provision and have more than 52 per cent of private inpatient beds. CHA member tertiary services also outperform other services in many of the measured patient outcomes.

There are many innovative PC programs operating across Australia aimed at meeting local population need, improving equity of access, enabling at home death and improving the knowledge-base of PC service delivery. Systemic barriers to continued improvements in PC including remuneration levels, funding models, fragmentation, workforce shortages and lack of awareness of PC limit the longevity of innovative programs and access to PC in general.

There are evidence-based societal and economic arguments for improving PC in Australia. PC is effective at relieving symptom burden and improving quality of life for those involved. PC can also support people to die in their setting of preference. In Australia, an estimated 54 per cent of people die in hospitals and only 14 per cent die at home[9], when 50 to 70 per cent of people prefer to die at home[10]. Fundamentally, poor access to quality PC, particularly community-based PC, means many Australians are unable to exercise their preferences at the end of their life[11].

Economic arguments are based on the cost-effectiveness of PC with overall savings attainable different in all settings.[12] Studies report that community-based PC is more cost-effective than tertiary care driving calls to expand community-based PC services[13]. In 2012, the Senate Community Affairs References Committee found that PC costs around $7,700 per episode in a sub-acute hospital care compared with $2,500 for community-based care[14]. The Silver Chain Group also estimates that each dollar invested in extending home-based PC services in NSW would free up $1.44 of expenditure on inpatient beds[15].

CHA has identified a number of priority areas requiring Government action:

Data

Data collection is a major challenge to the adequate resourcing of PC services. The management of data in each state jurisdiction and Commonwealth in how people record and quantify PC at various points in inconsistent. Until health services can understand and standardise how they collect and measure the

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[8] Australian Bureau of Statistics (ABS). Population Projections, Australia, 2012 (base) to 2101. Canberra: ABS.
[9] Productivity Commission. Introducing Competition and Informed User Choice into Human Services: Reforms to Human Services. Canberra; 2017. Report No.: 85.
[10] Foreman L. M., Hunt R. W., Luke C. G., Roder D. M. Factors predictive of preferred place of death in the general population of South Australia. Palliative medicine. 2006;20(4):447-53.
[11] Palliative Care Australia (PCA). Submission to the Productivity Commission's Inquiry: Introducing Competition and Informed User Choice into Human Services: Identifying Sectors for Reform. Canberra; 2016.
[12]May P., Normand C., Morrison R. S. Economic impact of hospital inpatient palliative care consultation: review of current evidence and directions for future research. Journal of Palliative Medicine. 2014;17(9):1054-63.
[13] Smith S., Brick A., O'Hara S., Normand C. Evidence on the cost and cost-effectiveness of palliative care: a literature review. Palliative medicine. 2014;28(2):130-50.
[14] Senate Community Affairs References Committee (SCARC). Palliative care in Australia. Report to the Senate, Australian Government. Canberra; 2012.
[15] Silver Chain Group. Submission to the Productivity Commission's Issues Paper. Human Services: Identifying Sectors for Reform. 2016.

data related to EOLC and PC services, it will remain difficult to determine the extent of need and how to best target funding.

CHA recognizes there needs to be better coding standards across the hospital sector between what is PC, what is EOLC, and what is treated in a non-designated program. This includes PC specifications, the setting, and the delivery of services. There is no guidance for coders on program identification or what level of clinical supports are being received and how to differentiate between EOLC and PC.

CHA recommend government agencies, specifically the Independent Hospital Pricing Authority (IHPA), consult with technical groups in the development of coding standards that would assist with capturing important data around access and usage. This would assist with better scoping and resourcing, enabling health services and policy-makers to more readily identify gaps and barriers to PC.

Equity

Funding for physicians and community care is inadequate to support the delivery of PC services. The MBS Review Taskforce should review the inclusion of items related to the provision of PC activity to permit flexibility in the provision of multidisciplinary holistic care, advanced care planning, and remuneration for items such as case conferencing, home visits, and telehealth.

Current funding models do not reflect the current practice in delivering PC services in the private sector. While some health funds have been receptive to exploring innovative models of care, these models are not consistent across the sector due to lack of engagement from health funds. This leads to inequitable access when patients are unable to access certain home or community-based PC services simply because they are with a different health fund than those who contract with the hospital for those services.

CHA members also provide community-based PC services in both the public and private sectors and are among the first organizations to provide PHI funded PC in the community setting. CHA community PC services face similar challenges to non-CHA services in achieving patient outcomes, constrained heavily by resourcing.

Workforce

Across Australia, there are currently 1.0 FTE PC physicians and 12.0 FTE PC nurses per 100,000 population.[16] This indicates a significant shortage of PC clinicians to cope with the increasing needs of an ageing population. To address the urgent shortage of trained PC nursing staff and specialists alongside tertiary education institutions, there needs to be a targeted PC workforce strategy to address the gaps and shortfalls in workforce support.

Educating clinicians from other disciplines on the principles of EOLC and PC is fundamental to the delivery of medical care. CHA recommends better funding for ongoing education programs for the wider health workforce to improve PC literacy.

<u>Recommended Budget Priorities:</u>

[16] Australian Institute of Health and Welfare 2019. Palliative care services in Australia. Canberra: AIHW. Viewed 03 February 2020, https://www.aihw.gov.au/reports/palliative-care-services/palliative-care-services-in-australia

8. Task IHPA with developing coding standards for EOLC and PC to better capture data around the delivery of services in the acute setting to understand the scope of need and target future resources.
9. Review a Medicare rebate for medical services provided for PC activity that accounts for holistic multidisciplinary care. Also establish Medicare rebates for PC telehealth services delivered by nurse practitioners.
10. Given the number of people who would prefer not to spend their last days in a hospital, set a national target that facilitates an increase in the number of people dying in their place of choice (whether that be at home or in a residential facility).
11. Strengthen community-PC models by funding new evidenced-based palliative specialist models, such as those which work with aged care facilities to identify those with palliative care needs and develops pathways to better manage their EOLC and reduce hospitalisations.
12. Expand PC education across the medical disciplines to improve clinical practice related to PC care and elevate the conversation to improve PC awareness with the public to enhance health literacy.

Equity in Health Outcomes for Vulnerable Populations

At the centre of the Catholic ethos is the belief in the essential dignity of each individual that is person-centred and life-affirming. Catholic services seek to foster a healing environment where providers act in the best interest of the patients, regardless of background or religion. Catholic hospitals in Australia have a long tradition of establishing themselves in areas of acute disadvantage to deliver care to the vulnerable. As an integral part of CHA members' mission is care for the poor, disadvantaged, and dying, CHA's members invest heavily in services that aim to reduce health disparities for vulnerable populations, often at a cost to the hospital. Catholic providers are concerned by the structural challenges to delivering services for those in need due to out-dated funding models and restricted agreements, particularly in light of a growing body of evidence that shows the needs of vulnerable patients differ from the general population. Introducing efficiencies and stability to the health sector is required to maintain such services.

Mental Health

Every Australian, regardless of their state of wellbeing, should have access to appropriate and timely mental health care that supports their economic and social participation. Economic and social participation amongst those vulnerable to mental ill-health is vital to maintaining a person's wellbeing. For some, this requires little to no support and for others, this may require significant, complex and intensive supports from multiple sectors including health and social services.

In Australia, the most vulnerable populations remain those most poorly served by our mental health system, including Aboriginal and Torres Strait Islander people and asylum seekers. We are experiencing unprecedented increasing demand for mental health services, particularly crisis services, in a system whose design prohibits the delivery of the best care.

There are at least four vastly different mental health systems operating in parallel, rarely in concert. These are the public and private hospital system, community and primary mental health systems and the NDIS. At each level of care patients and carers experience deep frustration at the lack of interface

between services; for example, between the public and private tertiary hospital system, between the tertiary system and community care and between the NDIS and all other forms of support.

Fragmentation of the mental health system is fundamentally driven by siloed funding models and is particularly marked between the public and private sectors. Further fragmentation is introduced by the establishment of PHNs as commissioning bodies, with variable readiness and lack of joint commissioning approaches particularly with local health districts (LHDs) or private hospitals and continued inadequate funding across the sector. This is compounded as there has been a limited federal response as action has primarily occurred on a state-by-state basis. A single source of funding for all mental health services will remove many of these barriers to efficient service delivery and can provide long term stability to the sector.

PHI should pay for the most efficient model of care, which is the right care in the right place. In some circumstances, those in the private system are unable to access publicly funded supports and are limited by what private health insurers are willing to fund outside of hospital. Removing barriers for private sector patients, including funding for physical health comorbidities and specialised treatments, would enable inclusive and comprehensive care.

There are numerous examples of where PHI efficiencies can be improved in mental health. These result from divisions in what will be funded by PHI and a lack of community services that cover the gap outside of what PHI covers. Of note, CHA does not support PHI funders directly providing community care for those requiring mental health treatment as it is inappropriate for insurers to decide what is the clinically most appropriate care. CHA supports the delivery of health services that are provided in the most appropriate setting for the patients according to best clinical evidence and patient preference, not restricted by PHI funders.

Asylum Seekers

Asylum seekers and refugees are among those most vulnerable due to the experience of torture, trauma, and stigma, including prolonged detention. The prevalence of mental illness among this population is estimated to be at least twice as high as migrants who have entered Australia on economic grounds, with at least half of this group experiencing post-traumatic stress disorder (PTSD).[17]

For many, lack of safety and fear create substantial barriers to engaging in effective health care to address the trauma. The nature of Australia's current immigration legislative framework causes further psychological strain. The mental health of asylum seekers has been shown to deteriorate the longer they await determination of their migration status. Lack of access to specialised services, difficulties in engaging in therapy due to the sustained periods of uncertainty and long term separation from family members exacerbates their vulnerability. Transparency around the level of health services asylum seekers receive while in detention has been limited and there are no Commonwealth agencies tasked with monitoring the health of asylum seekers either onshore or offshore.

Alcohol and Other Drugs

[17] Young P & Gordon MS. (2016). Mental health screening in immigration detention: a fresh look at Australian government data. Australasian Psychiatry, 24(1):19–2.

Having access to alcohol and other drug (AOD) services in the right setting and the right time is critical to the process of treatment and minimising the impacts of harm on individuals, families, and the greater community. Treatment is often tailored to the individual, considering the appropriate levels of clinical and social supports that address individual needs on the continuum of recovery.

Factors that include stigma, lack of coordination and integration between services, fragmentation in treatment delivery and funding, and lack of strategic policy direction has meant that many people are not receiving the services they need in the right setting and the right time. Direct investment in accompanying areas of need, e.g., housing, community services, and education, are also shown to have impacts on communities and disadvantaged groups that suffer disproportionately from the impacts of AOD. With costs estimated to be $55b a year in AOD harm, we all bear the economic and social costs in how we respond to these needs.[18]

CHA supports recommendations and priority actions outlines in the *National Drug Strategy 2017-2026* that emphasize the use of evidence-based methods, partner with associated organizations to innovate and respond to community needs, and draw on lived experience and participatory processes to engage with priority populations of need.[19] This requires a whole of Government response with greater cooperation and interagency support to advance this strategy.

Regional Communities

Our Catholic not-for-profit hospitals deliver a wide range of social and economic benefits to regional and rural communities that are at risk. It is critical to ensure the viability of these necessary services. We believe patient access and affordability should be a priority.

Continued access to regional and rural private health services could be compromised if funding arrangements do not adequately account for the higher associated costs of delivering services in regional areas. Some services in regional communities have already been reduced or closed. Access to highly trained medical staff can be limited outside metropolitan centres with more incentives required to draw young professionals to establish careers in regional communities.

CHA urges the Australian Government to consider these current issues faced by the private not-for-profit hospitals sector and the wider implications that the current downward trajectory of service provision will have for the health of those (one third of the population) living in regional and rural Australia.

Recommended Budget Priorities:

13. Continue to shift the focus of the mental health system from crisis and acute care to community-based services, primary health care, prevention and early intervention, including

[18] Collins, D, & and Lapsley, H, 2008, The costs of tobacco, alcohol and illicit drug abuse to Australian society in 2004/05, Commonwealth of Australia.
[19] National Drug Strategy 2017-2026. Department of Health, 18 Sept. 2017, www.health.gov.au/sites/default/files/national-drug-strategy-2017-2026_1.pdf.

increasing access to community-based supports following discharge from hospital, particularly for those at high risk of suicide.

14. Continue to move towards a single source of funding for all Mental Health services, thereby removing existing barriers (multiple systems with little integration) to efficient service delivery.
15. Improve the capability and capacity of Primary Health Network (PHN) commissioning processes for the delivery of local mental health services, including joint commissioning of services between PHNs, Local Health Districts/Areas (LHDs/LHAs) and Private Hospitals, where appropriate.
16. Improve funding and access to health services to meet the needs of asylum seekers, including greater transparency in the quality and delivery of care received.
17. Establish greater workforce and infrastructure supports for regional hospitals to ensure the skills and capital investments for quality and innovation are also available to regional communities.

Conclusion

CHA appreciates the governments continuing commitment to many of the reforms identifies in priority areas and looks forward to the opportunity to work with our Minister for Health and Department of Health on the budget and reform areas identified.

Yours faithfully,

Pat Garcia

Chief Executive Officer

Catholic Health Australia