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AFAO Response to the *A Healthier Future For All Australians,* Interim Report of the National Health and Hospitals Reform Commission

The Australian Federation of AIDS Organisations (AFAO) is the peak body for Australia's community sector response to the HIV/AIDS epidemic. AFAO is charged with representing the views of our members: the AIDS Councils in each state and territory, the National Association of People Living with HIV/AIDS, the Australian Illicit and Injecting Drug Users League, the Anwernekenhe Aboriginal and Torres Strait Islander HIV/AIDS Alliance (ANA) and Scarlet Alliance, the national organisation representing sex workers. AFAO provides HIV (and STI) prevention education and health promotion to members of affected communities. HIV policy advice to the Commonwealth Government, advocates for our member organisations, develops and formulates policy on HIV/AIDS issues, and promotes medical and social research into HIV/AIDS and its effects.

AFAO welcomes the opportunity to respond to this Interim Report suggesting future directions for reform of the Australian Health Care system. We have responded in the attached Submission, which directly addresses two of the major reform directions outlined in the Report.

Yours sincerely,

Don Baxter
Executive Director
AFAO

Introduction

The Australian Federation of AIDS Organisations (AFAO) is the peak body for Australia's community sector response to the HIV/AIDS epidemic. AFAO is charged with representing the views of our members: the AIDS Councils in each state and territory, the National Association of People Living with HIV/AIDS, the Australian Illicit and Injecting Drug Users League, the Anwernekenhe Aboriginal and Torres Strait Islander HIV/AIDS Alliance (ANA) and Scarlet Alliance, the national organisation representing sex workers. AFAO provides HIV (and STI) prevention education and health promotion to members of affected communities. HIV policy advice to the Commonwealth Government, advocates for our member organisations, develops and formulates policy on HIV/AIDS issues, and promotes medical and social research into HIV/AIDS and its effects.

Australia's evidence-based and partnership-oriented response to HIV is widely viewed as successful. In contrast to many other developed countries, Australia has managed to effectively contain the spread of HIV to the men who have sex with men (MSM) population, and avoided large-scale outbreaks among injecting drug user (IDU) and sex worker populations. The successful containment of HIV has resulted in the prevention of a "wide-scale" epidemic in the general population with Australia having very low HIV prevalence figures (measured per 100,000 of the general population). At the end of 2007, an estimated 16,692 people were living with HIV in Australia.[1]

The AFAO Submission is focused on the first two main reform Directions contained in the Interim Report.

Comments on the Proposed Reform Directions

Reform Direction 1: Building good health and wellbeing into our communities and our lives

AFAO strongly supports this area of the Interim report, particularly those areas which work directly with the challenges presented in working with the Social Determinants of health.

Direction 1.1 – We affirm the value of universal entitlement to medical, pharmaceutical and public hospital services under Medicare which, together with choice and access through private health insurance, provides a robust framework for the Australian health care system. To promote greater equity, universal entitlement needs to be overlaid with targeting of health care services to ensure that disadvantaged groups have the best opportunity for improved health outcomes.

AFAO supports the broad directions and message contained in this direction. However we believe that a robust framework for the Australian Health Care system should extend beyond medical, pharmaceutical and public and private hospital services and should include Public Health facilities, Health Promotion programs, Community development and education.

Direction 1.2 – We propose that public reporting on health status, health service use and health outcomes by governments, private health insurers, and individual health service providers identifies the impact on population groups who are likely to be disadvantaged in our communities.

AFAO supports the collection and public reporting of data across all aspects of the Australian health care system and recognises the fundamental role such data play in both planning and evaluation. AFAO believes

[1] National Centre in HIV Epidemiology and Clinical Research, HIV/AIDS, viral hepatitis and sexually transmissible infections in Australia Annual Surveillance Report 2008. National Centre in HIV Epidemiology and Clinical Research, University of New South Wales, Sydney, NSW

that the scope of this direction should be broadened to include data that impacts directly on health status such as information related to the social determinants of health.

This is particularly important when looking to shape health responses for population groups and communities who experience disadvantage. Individual health program responses need to be delivered alongside other social and economic solutions. The incorporation of such data is consistent with the Federal Government's commitment to Social Inclusion.

Direction 1.3 – We propose the preparation of a regular report that tracks our progress as a nation in tackling health inequity

AFAO broadly supports the concept of independent reports helping shape public policy and debate around health inequity in our communities. However, there is a risk that good reporting practice can be "hamstrung" through political and bureaucratic process and lack of political engagement.

Therefore we propose that this reform direction would be strengthened through further description of the proposed report (and those who work on it). Ideally, such a report would be independent of Government and able to work cross-sectorally. The creation and tabling of these reports should be a "public and open" process, with the report released both to governments and the broad public without intercession or interference.

Direction 1.4 – We support the development of accessible information on the health of local communities. This information should take a broad view of the factors contributing to healthy communities, including the 'wellness footprint' of communities and issues such as urban planning, public transport, community connectedness and a sustainable environment.

AFAO strongly supports this direction, but notes that communities do not just exist in "geographic" boundaries, but also through shared or common experience. These "communities of interest" include populations who experience significant health inequity such as people with HIV, gay men, and specific migrant populations.

Direction 1.5 – We support the delivery of wellness and health promotion programs by employers and private health insurers. Any existing regulatory barriers to increasing the uptake of such programs should be reviewed.

AFAO broadly supports the concept of providing health promotion in many settings (including workplaces and through private health insurers). However, it should be noted that the provision of wellness and health promotion services must be effective if they are to have real value (both to the individual and the community). Investment in health promotion should not be measured or valued solely in dollars spent across various campaigns. It is also important that the health promotion interventions are effective and result in real benefits for individual and for broader society.

AFAO has concerns that unless policy measures are taken, the efficacy and value of some of the wellness and health promotion activities would be compromised. Therefore we strongly suggest that monitoring and evaluation be included in the framework for any health promotion activity regardless of the site or provider of the program.

Direction 1.6 – We propose that governments commit to establishing a rolling series of ten-year goals for health promotion and prevention, to be known as Healthy Australia Goals, commencing with Healthy Australia 2020 Goals. The goals should be developed to ensure broad community ownership and commitment, with regular reporting by governments on progress towards achieving better health outcomes under the ten-year goals.

AFAO supports and endorses this direction.

Direction 1.7 – We propose the establishment of an independent national health promotion and prevention agency. This agency would be responsible for national leadership on the ten-year goals, as well as building the evidence base, capacity and infrastructure that is required so that prevention becomes the platform of healthy communities and is integrated into all aspects of our health care system.

AFAO supports and endorses the establishment of a national health promotion and prevention agency. We would like to particularly emphasise the concluding paragraph by the Commission regarding the formation of this new agency:

> We want to emphasise that national leadership on prevention and health promotion through the proposed new agency must involve a strong focus on cross-sectoral action, rather than being limited to action within the health portfolio only.[2]

This is particularly the case when working with communities to improve their health through the precepts of Community Development and Health Promotion. Community Organisations often seek to improve many aspects of life in the communities they work in. This work often falls outside the domain of the "health sector" (as it is broadly perceived) but plays an important role in shaping the Social Determinants of health towards better health outcomes. This work exists across a wide spectrum of agencies and issues.

For example, in response to the HIV epidemic in Australia, community based organisations have worked in legal frameworks (particularly in issues regarding discrimination), housing issues and socioeconomic issues (including income support). A health promotion and prevention agency that maintained an *a priori* focus on health might potentially jeopardise this work.

Direction 1.8 – We propose that the national health promotion and prevention agency would also collate and disseminate information about the efficacy and cost effectiveness of health promotion and prevention interventions.

AFAO broadly supports this direction but notes that a focus on the cost effectiveness of health promotion and prevention may have negative consequences. It is a commonly held belief that prevention and health promotion activities are, by definition, cost effective. However, recent data looking at cost effectiveness demonstrates that the situation is more complex and less easily understood. Many prevention activities which are considered successful – particularly in terms of preventing mortality and morbidity - may not be as cost effective as others[3]. This counter-intuitive conclusion stems from the additional costs generated through the extension of life expectancy.

Ultimately, a focus on cost effectiveness may place otherwise useful, effective and evidence based prevention and health promotion activities at risk. This is something that needs to be considered as part of the evaluative and decision making frameworks that fund such programs.

In addition, we suggest that the agency play a role in helping develop capacity across all agencies to evaluate their programs and collect data on efficacy, cost effectiveness.

Direction 1.9 – We support strategies that help people take greater personal responsibility for improving their health through policies that 'make healthy choices easy choices'. This includes

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[2] National Health and Hospitals Reform Commission, *A Healthier Future For All Australians – Interim Report December 2008*, 2008.

[3] Meltzer, D Response *to "Future costs and the future of cost-effectiveness analysis"* Journal of Health Economics 27 (2008) 822–825

individual and collective action to improve health by people, families, communities, health professionals, employers and governments.

AFAO has some fundamental concerns about the current framing and emphasis of this Direction and encourages the Commission to put considerable thought into to re-framing it conceptually.

While the Direction makes mention of 'collective action to improve health by people, families, communities, health professionals, employers and governments', the current wording has an overwhelming emphasis that is essentially a call for individuals to take greater personal responsibility for their own health.

Our experience in the HIV response has shown that placing the most emphasis on individual responsibility was only partially successful in preventing HIV infections. It ignored, the key drivers to behaviour change among those most at risk of HIV infection. While fear of infection was initially a significant change factor among those at risk, its potency reduced over time as some individuals took risks and did not become infected. This weakened its force as a motivator for behavioural change in the long term. What was found to be more powerful, particularly in *sustaining* change over the long-term, was how individuals perceived the norms and values of their own communities. These norms and values helped shape a discourse around what behaviour was acceptable, and unacceptable, between individual, their peers and their communities.

While new or changed values about acceptable/unacceptable behaviour could not be created by organisations (whether community agencies, health agencies or government bodies) – they are ipso facto, created by the community members themselves. The community organisations closely linked with their communities are in a position to influence these values and to strengthen them. This was done very effectively by the sex worker organisations in building condom availability and use every time in the sex industry (something which occurred before government agencies started funding them); by gay men introducing and 'normalising' the use of condoms in a population which had previously never used them; and, by drug injectors establishing informal (and at the time illegal) access to clean injecting equipment.

These actions are conceived of as a 'community mobilisation' strategy, where emphasis on responsibility is seen as both *shared and personal* – protecting the community you are part of as well as protecting yourself. The most effective mechanism in sustaining that sense of shared responsibility we have found to be strengthening community values around what is appropriate behaviour. An emphasis only on, or overwhelmingly on, personal responsibility leads to campaigns based on fear of illness and individual harm. We note that there is strong evidence that these strategies have only a limited and relatively short-term impact on the behaviour of those most at risk (while at the same time not encouraging those who are not at risk to assist those who are).

It might be argued that HIV transmission, as a communicable disease, is essentially a social act (i.e., it requires more than one person to be involved) and that community mobilisation strategies are not applicable to non-communicable diseases. That is to say major health issues such as smoking, poor diet and over-consumption of alcohol are essentially individual problems and hence not susceptible to the community mobilization strategies which have been successfully used in response to HIV.

We do not agree with this analysis. Smoking, drinking and eating are all essentially social acts. What has been missing to a large degree in addressing these issues has been the systematic application of a conceptual framework emphasising the social practice of these activities in contributing to bad outcomes and how a community mobilisation strategy might be designed to address each issue in its social and community context – not in a context which sees it as essentially individual problem.

An instructive example outside of Australia's HIV response is the comprehensive, multi-faceted approach taken in reducing sun exposure in young children. While many initiatives were taken to reduce this (mostly outside the health system) one of the key ones was mobilising the community of parents of young children. The extent and success of this strategy led to rapid changes on a very large scale in most educational, sporting and recreational facilities across the country.

AFAO will be taking these matters up in more detail with the National Preventative Health Taskforce. In the meantime however we encourage the Commission to re-frame its wording of this Direction towards making responsibility for better health outcomes a shared responsibility between individuals *and* the communities to which they belong.

Direction 1.10 – We propose that health literacy is included as a core element of the National Curriculum and that it is incorporated in national skills assessment. This should apply across primary and secondary school.

AFAO broadly supports and endorses this reform direction. In addition, we believe that this Reform Direction should explicitly state that the programs used to develop health literacy in schools should be developed in evidence-based frameworks and be free of moral or religious influence.

Direction 1.11 – We encourage all relevant groups (including health services, health professionals, non-government organisations, media, private health insurers and governments) to provide access to evidence-based, consumer-friendly information that supports people in making healthy choices and in better understanding and making decisions about their use of health services.

AFAO supports this reform direction.

Other issues – Financial incentives and prevention / Prevention Benefits Schedule

AFAO notes with interest the continuing discussion examining the financing of prevention. We believe that for health promotion and prevention activities to take place effectively, they need to be adequately and appropriately resourced and we support the Commission in trying to develop and explore new mechanisms to do this.

Our main concern regarding the two options outlined is that they focus on the individual (through individual financial motivators) and the health professional (through the creation of a Prevention Benefits Schedule). At a population health level, community agencies are often best placed to participate in health promotion and prevention. We believe that any discussion that seeks to explore the issue of financing prevention needs to include these agencies which are essential in influencing changes in community values towards more healthy behaviours.

Reform Direction 2 – Creating strong primary health care services for everyone

Direction 2.1 – We propose that, to better integrate and strengthen primary health care, the Commonwealth should assume responsibility for all primary health care policy and funding

AFAO acknowledges that the current funding and administrative model hampers the effective delivery of quality primary health care services in Australia. However, we are concerned that there is a lack of clarity in this Reform Direction for specialist sexual health services and community health services. Ultimately, AFAO is concerned that such a ‘broad stroke’ approach to primary health reform works better for generalist primary health care services than it does for specialist services.

In addition, AFAO is concerned that whilst the Commonwealth would be responsible for broad policy and funding; the State and Territory governments would still be responsible for service planning and provision. For this model to work, AFAO believes that a collaborative approach to service planning needs to exist. This collaborative approach would ideally involve governments (both Commonwealth and State and Territory) as well as other key stakeholders (such as health professionals and community).

Finally, the Commonwealth Department of Health and Ageing would require substantial additional capacity to adequately administer such a broad policy shift. This needs to be reflected in the final report of the Commission alongside recommendations for the provision of this additional capacity.

Direction 2.2 – We propose that, in its expanded role, the Commonwealth should encourage and actively foster the widespread establishment of Comprehensive Primary Health Care Centres.

AFAO acknowledges that there are significant advantages to be gained (for both health consumers and governments) in the creation of Comprehensive Primary Health Care Centres. However, AFAO is concerned by the inclusion of the private hospital system in the discussion around this issue.

AFAO believes that primary health care services should be provided (and funded) through public mechanisms to avoid the creation of a "two tier" medical system. The danger inherent in a "two tier" system is the gradual migration of skill, expertise and talent to the "wealthier" private health system which would result in poorer quality health care for those unable to access it.

AFAO believes that private hospitals do play a role in Australia's health care system, but believes that an inclusion of the private system into this discussion is at odds with Reform Direction 1.1 in this report.

Direction 2.3 – We want young families and people with chronic and complex conditions (including people with a disability or a long-term mental illness) to have the option of enrolling with a single primary health care service to improve care. To support this, we propose that:

- **There will be grand funding to support multidisciplinary clinical services and care coordination for that practice tied to levels of enrolment of young families and people with chronic and complex conditions.**
- **There will be payments to reward good performance in outcomes including quality and timeliness of care for the enrolled population.**
- **Over the longer term, payments will be developed that bundle the total cost of care of enrolled individuals over a course of care or period of time, in preference to existing fee-based payments.**

AFAO supports the development of novel and innovative models of care, particularly those models that support collaborative clinical partnership and provide more accessible, high quality care. However, AFAO believes that moving to a model based on centres designed to provide for all the care needs of health consumers may act to reduce consumer choice.

It is not inconceivable that whilst clinical collaboration will flourish within the Comprehensive Primary Care centres, partnerships and care arrangements which rely on health service providers outside the Comprehensive Primary Health Care centre may suffer. This is particularly true where a funding model implicitly encourages "one stop shop" arrangements such as those articulated in the Reform Direction.

> Over the longer term, payments will be developed that bundle the total cost of care of enrolled individuals over a course of care or period of time, in preference to fee-based payments.[4]

AFAO believes that many health consumers might benefit from this model. However, some consumers, particularly those with more than one health condition, may experience poorer quality care across the continuum of their care needs if they are unable to access the appropriate specialist support.

AFAO notes that participation in this 'enrolment' process would be voluntary, and determined by the health consumer. However, despite the best efforts of policymakers, it is reasonable to expect a certain level of

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[4] National Health and Hospitals Reform Commission, *A Healthier Future For All Australians – Interim Report December 2008*, 2008. p. 93

“automatic” enrolment for some patients, particularly those with chronic and complex conditions, and those experiencing diminished agency (as a result of socio-economic hardship, disability or poor health literacy).

Direction 2.4 – We support embedding a strong focus on quality and health outcomes across all primary health care services. This requires the development of good outcomes data for primary health care. We also want to see the development of performance payouts for prevention and quality care.

Whilst AFAO supports health policy measures that actively encourage and support better health outcomes for health consumers, we have some concerns regarding this reform direction. Specifically, a focus on rewarding good health outcomes and quality care may create an environment for health care professionals where it becomes financially punitive to take on patients who are unlikely to result in the best outcomes and for whom the provision of quality care may be problematic.

This is particularly true for health consumers who already experience significant social disadvantage and health inequity; such as Aboriginal and Torres Strait Islanders, people with severe psychiatric conditions, people with intellectual disabilities, migrants and people from culturally and linguistically diverse backgrounds, the homeless and people with alcohol and other drug related conditions.

AFAO believes that this Reform Direction may directly contribute to health inequity, and direct policy intervention will be required to prevent this from occurring.

Direction 2.5 – We support improving the way in which primary health care professionals and specialists manage the care of people with chronic and complex conditions through shared care arrangements in a community setting. These arrangements should promote the vital role of primary health care professionals in the ongoing management and support of people with chronic and complex conditions.

AFAO supports and endorses this recommendation.

Direction 2.6 – We believe that service coordination and population health planning priorities could be enhanced at the local level through the establishment of Divisions of Primary Health Care, evolving from or replacing the Existing Divisions of General Practice. These divisions will need to be of an appropriate size to provide efficient and effective coordination.

AFAO believes that service coordination and population health planning are essential to the provision of quality, appropriate primary health care. Our main concern with this direction is that the mechanism proposed (evolving the Divisions of General Practice) may place an overly medical focus on broader population health and service planning issues.

Direction 2.7 – We propose facilitating access to care where doctors are scarce. Commencing in remote and some rural areas:

- **Medicare rebates should apply to relevant diagnostic services and specialist medical services ordered or referred by nurse practitioners and other registered health professionals according to defined scopes of practice determined by health professional registration bodies.**
- **Pharmaceutical Benefits Scheme subsidies (or, where more appropriate, support for access to subsidized pharmaceuticals under section 100 of the *National Health Act 1953*) should apply pharmaceuticals prescribed from approved formularies by nurse practitioners and health professionals according to defined scopes of practice.**
- **Where there is appropriate evidence, specified procedural items on the Medicare Benefits Schedule should be able to be billed by a medical practitioner for work performed by a competent health professional, credentialed for defined scopes of practice.**

AFAO broadly supports the concepts outlined in this reform direction and would like to refer the work of the "Models of Access and Clinical Service Delivery for People With HIV Living in Australia" project commissioned by the Blood Borne Virus and STI Subcommittee of the Australian Population Health Development Principal Committee Commonwealth Department of Health and Ageing.

The project aims to evaluate the effectiveness of the current models of access and clinical service delivery for HIV positive people and update them. The results of the evaluation will inform any changes required for the future care models, including workforce capacity and education.

The project is overseen by an advisory group with members from State and Territory Health Departments, Community Organisations, clinicians, researchers and the Commonwealth Department of Health and Ageing.

Direction 2.8 – In accordance with our later proposal for the establishment of a National Aboriginal and Torres Strait Islander Health Authority, we would expect that this Authority should be responsible for the purchasing of services that encourage and promote best practice and quality outcomes in primary health care for Aboriginal and Torres Strait Islander peoples wherever they elect to seek their health care.

AFAO supports and endorses this reform direction.

Direction 2.9 – We support the development of a person-controlled electronic personal health record. We will explore the prerequisites and incentives to allow us to reach this goal in our final report.

eHealth should play a vital role in modernising and improving Australia's Health Care system at all levels. Despite significant investment from both Commonwealth and State governments, this promise has yet to be fully realised.

The development of a better health information management system, which enables information sharing across a complex and fragmented health system, is essential to the provision of safe, high quality care. Furthermore, existing deficits identified in health care information management are attributed as a major cause of serious events and 'Sentinel' events in Australia[5].

It is apparent that any discussion, or strategy that seeks to improve the safety and quality of care in the Australia health care system must consider (and ultimately incorporate) appropriate eHealth technology. Strict guidelines and auditing measures in relation to the protection of individual confidentiality and privacy for electronic medical records and patient records are essential for the integration of this technology into the public healthcare system.

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[5] Australian Institute of Health and Welfare & Australian Commission on Safety and Quality in Health Care 2007. Sentinel events in Australian public hospitals 2004–05. Cat. no. HSE. 51 Canberra: AIHW.