Australian Federation of AIDS Organisations

Submission to the National Health and Hospitals Reform Commission

5 June 2008

Comments on the Proposed Principles

1. People and family centred

AFAO believes that, while the emphasis on a 'people' and 'family' centred health system is commendable, it is also important to recognize the role of communities in health. The Ottawa Charter for Health Promotion [World Health Organisation, 1986] recognizes the key role of communities (and community development) in the promotion of a healthy society. This was then further refined in the Jakarta Declaration [World Health Organisation, 1997] which placed greater emphasis on the importance of capacity development for communities to empower individuals.

AFAO notes that major successes in prevention owe much of their success to deliberately fostering and supporting changes in community values about appropriate behaviour. Examples such as Australia's response to HIV/AIDS in the 1980's and 90's and the '*Slip, Slop, Slap*' skin cancer prevention campaign highlight the obvious, but sometimes overlooked, fact that nearly all healthy challenges and decisions about behaviour occur in a social, as opposed to an individual psychosocial, context.

This principle should place more explicit emphasis on the role of communities in health. AFAO therefore recommends that this principle be renamed, to better reflect the important role of communities in health.

2. Shared responsibility

Models of shared responsibility are becoming increasingly dominant as neo-liberal principles underpin the development of social welfare policies such as mutual obligation. Whilst AFAO recognizes the important role of the individual in helping to maintain their own health, we believe that this principle should also articulate the necessity for information and support to enable individuals to meet their responsibilities. This principle requires greater emphasis on the role of governments and health systems in developing the capacity of people, families and communities in achieving better health outcomes.

3. Comprehensive

A comprehensive and more diverse understanding of what health is, and how it is achieved needs to be incorporated into this principle. The health system is far greater than the hospital and clinical model and includes community health, health promotion agencies and other psychosocial support vendors. AFAO also notes that most preventative health activities and measures necessarily occur outside of the traditional health system agencies.

AFAO believes that this principle needs to place explicit emphasis on a broader and more inclusive understanding of the health system; on which people rely to meet the diversity and multiplicity of their health needs.

Other comments:

Public Voice

AFAO supports the involvement of consumers and carers in decision-making, not only in relation to their own healthcare but in relation to the health system as a whole. We therefore support this principle. However, it is important to recognize the role of organisations in providing input into the development of health policy and programs, as well as the role of individuals *qua* individuals. Advocacy organisations have a legitimate role in representing the interests of their members in the policy process. In particular, unions and other professional associations have an important role in representing the health workforce.

Quality and Commitment to Excellence

The important role of quality in both clinical, and research, processes needs to be incorporated into this principle. Australians deserve, and have come to expect, a health care system that consistently strives to offer best practice care, treatment and support and a health care system that is leading edge in research and professional development.

Whilst the proposed governance principles do include "a culture of reflective improvement and innovation", AFAO believes that a core principle for the Australian Health Care System needs to have an explicit commitment to excellence and best practice. This principle needs to explicitly articulate the importance and centrality of research as part of the long term Australian health agenda, and the importance of incorporating research into practice.

Comments relating to *'Beyond the Blame Game: Accountability and Performance Benchmarks for the next Australian Health Care Agreements'*

Health challenges

1. Closing the gap in Indigenous health status

AFAO fully supports the placement of this principle as first among the challenges facing the Australian health system. The health of Indigenous Australians compared to that of the wider community remains so poor that closing this gap must be a primary priority. Our only question in regard to this challenge – which the Commission may already have grappled with – is whether additional, specific benchmarks relating to Indigenous health should also be included in other challenges. Indigenous communities face particular challenges in relation to chronic illness, child health, access to services and maintaining a strong health workforce, to name but a few key areas. However, the proposed benchmarks (which we acknowledge are provisional) include only two items specifically relating to Indigenous health. We recommend further benchmarks relating to Indigenous health be included.

2. Investing in prevention

AFAO supports the increased emphasis on investing in prevention. However, our concern in regard to this challenge is that prevention here appears to refer only to prevention of chronic illness. Continuing prevention efforts in relation to communicable diseases should remain a priority for the health system. Communicable diseases such as HIV/AIDS and hepatitis C are also chronic illnesses that form a significant burden on the health system. Effective prevention of communicable diseases also requires different approaches to those responding to other chronic illnesses such as diabetes.

4. Recognising the needs of the whole person

As the Report notes, there are currently key gaps in access to health services in relation to dental care and mental health. These gaps in service access and provision have severe consequences for consumers and carers. We are not convinced that other gaps in Medicare funding, such as lack of funding for complementary medicines, are of the same order as issues in relation to mental and oral health that inclusion in this challenge implies. While holistic health care is an important principle, we feel that mental health and dental health present significant challenges for the health system in themselves. Further, it is questionable whether the Commission's position that 'mental health and oral health care needs should not be treated as separate to the needs of the whole person' is best served by their inclusion in this challenge, which may still imply that these needs are somehow 'extra' or ancillary to other health needs. For example, we note that the proposed benchmarks relating to mental health refer to access to community-based mental health services. While this is an appropriate benchmark that AFAO supports, we

note that the benchmarks for hospital access make no reference to acute mental health services, which surely remains a key area of mental health service provision.

7. Quality of care and respecting the needs of people at the end of life

While mortality from AIDS-related conditions has declined significantly in recent years, AFAO recognizes the continuing importance of providing appropriate palliative and end-of-life care for all. Problems with the implementation of advanced care directives and communication with patients and carers remain a source of considerable distress for people at the end of life. We therefore support the emphasis on caring for and respecting the needs of people at the end of their lives as a continuing challenge for the health system.

Other comments

Towards clearer accountability by governments for health services

We understand the Commission's rationale in assigning different responsibilities to Commonwealth and state governments, and do not support an arbitrary assumption of full responsibility for the health system by a single authority. However, we are seeking more information about both the rationale and potential operation for the proposed areas of responsibility. It is clear that the new Australian Health Care Agreement will have a significant broader focus than the current one; however, there is virtually no information available about the content or the operation of the new Agreement at present. The Commission's report, for example, refers to potential 'financial consequences' (p. 20) for reduced performance, but provides no information about how this might work in practice, or how it might function to improve the performance of the Commonwealth as well as that of the states.

The assignment of responsibility for different functions may be problematic, as there is considerable potential for overlap between these functions. For example, while the Commonwealth is to have responsibility for prevention and the states for public health, an obvious question is who will assume responsibility for public health prevention programs? Similarly, while the Commonwealth is to have responsibility for Indigenous health and the states for child health, how will the health of Indigenous children be managed and prioritized? As the Commission's stated goal is to 'end the blame game', we are concerned that an inadequately planned assignment of responsibilities may result in a continuation of the 'blame game' in a different form.

Context for the Commission's work on performance benchmarks

AFAO notes the Commission's acknowledgement that the next AHCAs are likely to include broadbanding of other health agreements including the Public Health Outcome Funding Agreements. The PHOFAs are of particular interest to AFAO, as this is the

mechanism through which state HIV/AIDS programs are currently funded. While we acknowledge the Commission's point that there are a number of policy processes which will shape the future AHCAs, AFAO is disappointed that the Commission's proposed benchmarks do not include any benchmarks relating to public health outcomes currently included in the PHOFAs. Further, we are deeply concerned that the tight timeframe for the completion of the Commission's work will not allow for adequate consideration of the PHOFA benchmarks and the implications of their incorporation into the AHCAs. The Commission's proposed guiding criteria for the development and use of performance benchmarks (p. 24-28) are sound, and we urge the Commission to prioritise the development of effective benchmarks relating to public health and communicable diseases.