



National Health Policy Summit

Communique

1. On 3 March 2017, the Australian Labor Party convened the National Health Policy Summit at Parliament House in Canberra. The Summit brought together around 160 of Australia's leading thinkers on health, as well as more than 20 Labor MPs including Leader of the Opposition Bill Shorten, Shadow Minister for Health and Medicare Catherine King and Shadow Minister for Mental Health and Ageing Julie Collins.
2. The Summit was a milestone in Labor's policy development process. Labor is proud of the health policies it took to the last election, and of its record in Government. But the Summit was an opportunity to listen to leading stakeholders and experts about how national health policies and programs need to evolve into the future. Through eight roundtable discussions (summarised below) and two plenary sessions, participants outlined the reforms our health system needs if it is to continue to meet the changing needs of all Australians.
3. Labor thanks the stakeholders and experts who attended the Summit, as well as those who engaged with the Summit remotely. Labor also thanks the nine health leaders who chaired roundtable discussions and contributed to this Communique. As we prepare for the next election and a Shorten Government, Labor is committed to working with Summit participants – along with other consumers, health providers and experts – to develop and refine health policies that ensure equity, universal access and world-class outcomes (see 'Next Steps' below).

Roundtable discussions

Protection, prevention and promotion

4. Participants highlighted the chronic disease crisis, noting that at least one-third of these diseases are preventable. They also emphasised the main risk factors that contribute to this crisis, such as weight gain, unhealthy foods, lack of physical activity, tobacco use, and alcohol. Participants noted that these were national challenges and would require system-wide responses to promote health and wellbeing across all age groups.
5. A common theme was the impact of inequity on health. It was recognised that some groups faced particular challenges and would benefit from more targeted government support – such as Aboriginal and Torres Strait Islander peoples, people in remote Australia, mothers and infants, and people with disability. However, the broad range of social determinants impact heavily on health. Participants also recognised that mental health and suicide are key issues affecting Australian families and



communities, particularly affecting young people and LGBTIQ people, and these require national, coordinated strategies.

6. Participants called on governments to focus on implementation and action, not reviews. They felt that the evidence was already quite clear in most areas, although they noted that ongoing support for national surveys and data collection is required to monitor progress, for example through the National Health Survey. Participants argued that the Commonwealth could improve implementation by partnering more closely with communities, states and territories, the public health sector and industry. They also called for stronger public health messaging from governments, to improve Australians' understanding of how people's health is strongly influenced by surrounding environments and how people can be empowered to manage their own health. Participants felt that establishing environments that facilitate making the healthy choice the easy choice is an important role of government.
7. Participants also called on governments to adopt a 'health in all policies' approach. This would recognise that a wide range of factors – like education, housing, employment and economic inequality – affect health. Such an approach would help to break down silos within government. For example, the group argued that governments should address climate change and its impacts on health, and better integrate health and disability policy. As well as this overall approach, participants called for targeted interventions on some issues – like mass media campaigns on tobacco, restrictions on marketing of junk food and alcohol (particularly to children), breaking the nexus between these unhealthy products and sport, as well as implementing taxation measures to mitigate the harmful consumption of alcohol and junk food – in particular sugar-laden soft drinks.

Primary, secondary and community care

8. Participants applauded the major expansion in access to primary care over the past half century – particularly to medical services through Medicare and medicines through the Pharmaceutical Benefits Scheme. But while access has improved, participants emphasised that care remains fragmented, and that outcomes for patients and efficiency for funders are largely unknown in primary care.
9. Participants called for a stronger narrative from governments on the *purpose* of health policies and programs. They felt that this narrative should be focussed on equity, access and outcomes.
10. Participants also argued that governments should see expenditure on primary care as an investment opportunity. They noted that around half of all health spending is in primary care, and called on governments to leverage this expenditure to make care



more patient-centred, improve outcomes, and reduce unnecessary hospitalisations. Participants also suggested tools that governments could use to achieve these aims, including integrated data and analysis, an outcomes framework and indicators, blended funding to allow more flexible services, and integrated models of care that use professional capabilities more effectively.

11. Participants expressed concern about the way that health policies and programs are currently designed and delivered. They felt that decision-making is too centralised in the hands of ‘insiders’ in Canberra, and argued that governments should recognise the importance of subsidiarity and encourage place-based decision-making. In particular, the group called for greater community control of policy, planning and governance processes, particularly (but not exclusively) for Indigenous communities.

Hospitals

12. Participants discussed the balance between access to public and private hospitals in Australia and that any future policy needs to give careful consideration to the impact of policy decisions impacting on this balance.
13. It was generally agreed that there is a lack of access to hospitals, whether it be in the private or public sector, but that this was especially the case in the public setting. This was particularly the case in relation to elective surgery. In this context, there was a discussion around the accuracy of the reporting of waiting times and the importance of improving access.
14. Participants agreed that consideration should be given to policies that ensured hospitals concentrate on delivering their core business – that is acute care. Increasingly, patients with chronic illness, whether they be living in aged care facilities or at home, are presenting at emergency departments and being treated in hospital for long periods when they could be treated in the community. This was equally true of ambulance resources that are increasingly treating patients with chronic illness instead of concentrating the majority of their work on emergency care.
15. There was also a discussion around the issue of subacute services and outpatients and, in particular, how issues of Commonwealth and state/territory funding create access difficulties and may affect appropriate care of patients.
16. Participants discussed the role for better data and data sharing arrangements between primary care providers and hospitals to better monitor a patient’s whole episode of care and to monitor outcomes. It was generally agreed that better data sharing, including within hospitals, was an underdeveloped opportunity and could lead



to improvements into a patient's quality of care, as well as improve the efficiency of the health system.

17. Questions were also raised about whether the existing block funding arrangements for regional and rural hospitals were the most appropriate in the context of broader changes associated with Activity-Based Funding.

Mental health and suicide prevention

18. Participants agreed that more needed to be done in the short term to address Australia's mental health burden and the growing rate of suicide. There was an agreed view that the National Mental Health Commission's review and recommendations were a solid framework for reform and it was time to implement this plan.
19. There was agreement mental health should be given a higher priority, substantially more funding, and that it was a weak point of the health system given it is 20 per cent of the health burden. It was also established that mental health should be an important part of the economics agenda within an 'invest to save' context. Participants highlighted a range of challenges and issues including the urgent need to address service delivery gaps, particularly in psychosocial support and between the GP and the ED, investment to be made in services and at a community level, and an emphasis to build the evidence base as well as building resilience across communities.
20. In relation to suicide prevention challenges, participants highlighted the need to address trauma in Aboriginal and Torres Strait Islander communities, develop a national suicide prevention strategy including a standalone strategy for children and young people, build workforce capacity, improve and better co-ordinate data collection and provide community connections in hospital systems. Suicide Prevention Australia raised its view there is a need to establish a National Office for Suicide Prevention and put before Parliament a National Suicide Prevention Bill.
21. Participants also emphasised the need for the Commonwealth to lead state and territory collaboration on issues around funding and service delivery. There was also agreement from participants that long-term national leadership was urgently required to address mental health and suicide prevention. This would involve establishing clear national targets for action, and supporting timely and transparent reporting on progress.

Tackling health inequality and other whole-of-government challenges

22. Participants agreed that Aboriginal and Torres Strait Islander peoples faced persistent and acute barriers to health equity and therefore must remain a top priority. Many of these barriers, like racism, are structural, evident both within the health system and



more widely. In response, Indigenous health leaders and other participants called for governments to re-commit to Indigenous self-determination, which also acknowledges the importance of the cultural determinants of health. Aboriginal and Torres Strait Islander peoples and communities should be supported in leading the design and delivery of health policy and services in partnership with governments and other stakeholders.

23. Participants highlighted the health inequalities faced by many Australians, including people with disabilities, people with mental illness, people who live outside cities, people from culturally and linguistically diverse backgrounds, and people with rare diseases. In response to these inequalities, participants called for wraparound services that break down silos (for example, between health and disability services) and improved care and support.
24. More broadly, participants noted that all Australians are affected by health inequalities to some extent. The group called for governments to adopt an approach based on fairness and equity towards all Australians, underpinned by a 'social determinants of health' framework (though participants noted that the framing of this approach could be developed further). Under this approach, the health sector would steward action in a range of policy areas that affect health and health equity – such as taxation, employment, social policy, housing and climate change. Participants noted that the Senate inquiry into Australia's response to the World Health Organisation Social Determinants of Health Commission provided a blueprint for this approach.
25. Participants also called for governance changes which were based on principles of participation and inclusivity, thus empowering individuals and communities. They felt that governments should steer action for better health for all but do this in a collaborative way with individuals, communities, not-for-profits, think-tanks, and other stakeholders. Participants also argued for better collection and analysis of data, and research funding to measure the impact that actions in health and other sectors have on health inequality.

Ensuring universal access for all Australians

26. Participants agreed that Australians have a right to universal access to world-class health care. But they emphasised that rising out-of-pocket costs have become a critical barrier to access. They also highlighted that barriers to access are higher for some people (including Indigenous Australians), in some areas (including regional, rural and remote Australia), and for some services (including mental health, allied health and dental services).



27. In response to these challenges, participants called for governments to protect Medicare – Australia’s universal public health system. They also argued that governments should see health spending – particularly on prevention and primary care – as an investment, not a burden. Participants also argued for stability and certainty in policy settings, saying that governments should pursue reform but not make change for change’s sake (for example, some participants felt that the transition from Medicare Locals to Primary Health Networks had been unnecessarily disruptive and wasteful).
28. In this context, participants called for governments to explore efficient ways of expanding access to health care services. These could include telehealth, better use of data in primary care, and consideration of how different health professions can interact differently. Participants also called for Commonwealth, state and territory governments to work more closely together, noting that many Australians are falling through the gaps of our federal system, and that reform is needed in states and territories as well as nationally.

Innovation across our health system

29. The group discussed the fragmentation that exists in the health system and how the overall quality of the system could be improved by reducing it. This applies between states/territories and the Commonwealth, across health care settings and also between the public and private systems.
30. Participants agreed that Australia has an excellent health and medical research sector and that research is important to inform changes to the health system. It was equally agreed that there are not enough opportunities for researchers which sees some of our most talented move overseas. There will be some benefit from the Medical Research Future Fund (MRFF). We perform very poorly when it comes to the commercialisation of medical research and the MRFF should help with this.
31. One additional way this research could be better supported is through philanthropy. Participants discussed that Australia is by no means as philanthropic as other countries and this is potentially an underutilised source of support for health and medical research.
32. Better use of data was a theme that came up throughout the discussion, especially in relation to improving the efficiency of Australia’s health care system and moderating the expected increase in cost. This included a call for a National Data Summit to address the known problems in coordinating and harnessing this data and developing some political will and agreement to address some of the challenges that will arise in doing so.



33. Participants also discussed the changing nature of Australia's health care system and the innovations that will need to be introduced to keep pace with them. Specifically, this applied to the increasing use of personalised medicine, demand for person-centred care and the integrating of specialties. Ultimately this will mean looking at different ways of providing and funding care, focussed more on a person's whole care/ongoing care rather than funding it in an episodic and fragmented way.
34. The group argued that investing in and supporting research, collaboration and partnerships at local, national and international levels should be promoted including engagement of people with a lived experience and the community. A focus on conversion of new evidence and invention into better health care and outcomes, as well as new business, jobs and exports was supported to harness the value of research.

Equipping Australia's health workforce for the future

35. Participants agreed that governments should see health workforce policies and programs as an opportunity to deliver services closer to home. Doing so would require a whole-of-government approach, since the health workforce is spread across several portfolios. Participants emphasised that the Commonwealth could improve service delivery by leveraging its investments – including in Medicare, Commonwealth-state agreements (such as on public hospital funding), and funding for education, clinical placements and specialist training.
36. In this context, participants called for governments to rethink how the health workforce operates. One focus was ensuring that the right professionals – doctors, nurses, allied health providers and other health providers – do each job, including by encouraging all practitioners to work to their full scope of practice. Another was better supporting the health workforce – such as by improving workplace cultures and psychological support, maintaining funding for cadetships and traineeships, and recognising the vital contribution of carers and volunteers.
37. Participants emphasised the importance of robust workforce data and planning, following the abolition of Health Workforce Australia. They felt that there was reasonable data on health professions that are regulated under the National Law, but very poor data on self-regulated professions and unregulated health care workers. Participants also highlighted the need for a strong clinical academic workforce to collect and analyse data.



Next steps

38. Labor took a strong health platform to the last election, which will inform policy development in this term of Parliament. Labor's 2016 election policies are available at www.100positivepolicies.org.au and include:
- Establishing a permanent Australian Healthcare Reform Commission, to embed reform in the architecture of our health system and avoid the 'boom and bust' cycles that have marred Commonwealth policy in recent years;
 - Investing \$300 million to build healthy communities and prevent chronic disease, including through Australia's first National Physical Activity Strategy and a National Nutrition Framework;
 - Investing \$100 million to develop new models of primary care and \$35 million to improve palliative care; and
 - Reversing the damage done by the Abbott-Turnbull Government, including by ending the Medicare freeze, scrapping PBS co-payment increases and cuts to bulk billing incentives for pathology and diagnostic imaging, and re-instituting the historic National Health Reform Agreement on public hospital funding to 2020.
39. Labor is committed to working with Summit participants and other consumers, health providers and experts to refine and develop its health policies over this term of Parliament. As part of this commitment, Labor will convene more detailed discussions on priority issues that have been identified by the Summit (or other consultations). Based on feedback from Summit attendees, Labor will also consider re-convening the National Health Policy Summit, for example ahead of Labor's National Conference.
40. Labor will also continue to engage with all interested parties on an ongoing basis. To begin or continue your discussions with Labor, please contact the following staff in the first instance:
- Alex White (Shorten), Alexander.White@aph.gov.au
 - Andrew Garrett (King), Andrew.Garrett@aph.gov.au
 - Lisa Mycko (Collins – Mental Health), Lisa.Mycko@aph.gov.au
 - Simon Monk (Collins – Ageing), Simon.Monk@aph.gov.au