CATHOLIC HEALTH
Australia

The Hon Josh Frydenberg MP
Treasurer
Parliament House
CANBERRA ACT 2600

Dear Treasurer,

Pre-Budget Submission 2021-22

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 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 recognised as having one of the best health systems in the world, based on 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]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 they have either 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.

CHA notes that the 2020-21 budget was delivered only several months ago due to COVID-19, and that the consultation process for the implementation of those policies is still underway. As such, CHA is contributing to this consultation process and welcomes the ongoing engagement by the Department of Health on these matters. Of particular note is the Consultation Paper: *Options for reforms and improvements to the Prostheses List* (December 2020). Some of the options canvassed through this paper pose significant risk to the viability of the private hospital sector, particularly so should the General Miscellaneous category be arbitrarily removed from the Prostheses List (PL) without a

[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

confirmed alternative patient benefit contribution for these items. Therefore, CHA provides this pre-budget submission in the context of prostheses and private health insurance reform already underway.

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

- Improve health access for patients through the continued expansion of the Out of Hospital care sector and telehealth services;
- Greater resourcing for end-of-life care and palliative care services;
- Equity in health outcomes for vulnerable populations.

Key Budget Recommendations:

The following recommendations are provided as CHA's priority recommendations, extracted from the complete submission which follows:

1. Retain MBS telehealth items and expand telehealth services to admitted patient care.
2. Support the expansion of Out of Hospital Care services in the private sector, based on the recommendations in CHA's report ***Out of Hospital Care in Australia: Advancing Health's Missing Sector.*** Noting the Government's commitment to this reform, commencing with at-home rehabilitation and community mental health services in 2020-21, this expansion should continue with support for more palliative care services delivered at home and other acute services being facilitated in a home environment.
3. Support the appropriate expansion of palliative care and end of life services:
    a. Implement 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.
    b. 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).
    c. 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.
    d. Expand palliative care education across the medical disciplines and elevate the conversation to improve palliative care awareness by the public.
4. Expand resources for services targeted towards vulnerable populations and recognise the complex and interdependent factors that require a multidisciplinary approach to addressing these wicked problems.

Improving Access for Patients

Telehealth Expansion

In March 2020, the Government announced they would be expanding temporary telehealth MBS items in order to protect patients and medical professional from community transmission and potential

exposure to COVID-19 while maintaining access to essential care. This list of MBS items has appropriately broadened over the course of the pandemic response efforts.

With the introduction of the new MBS items, telehealth services have been widely used in lieu of face to face patient interactions across many Catholic health services, including pre-admission consults, post-natal support, outpatient consults for chronic diseases, and a wide range of rehabilitation, mental health and other community-based services, including social outreach programs and disability services.

Telehealth services, when delivered appropriately, achieve the quadruple aims of healthcare – not only are they cost effective and overall improve patient outcomes, but they improve patient and clinician experience by reducing barriers to accessing timely care. Initial feedback from patients has been overwhelmingly positive and demonstrates that our communities support the use of telehealth so they can access safe, convenient care from either their home or work environment. Our sector has reported lower cancellation rates and higher satisfaction rates for patients who do not need to attend face to face appointments thus improving productivity for both the service providers and patients. Similarly so with clinicians: in a survey conducted by the Royal Australasian College of Physicians (RACP), 75% of physicians believed the availability of these new items increased the accessibility of services to patients and 87% of responding physicians supported retaining the new telehealth items[4]. Importantly, telehealth services appear to be of most benefit to the poor, vulnerable and marginalised in our community, providing access to services where it is most needed.

In addition to continuing the current MBS list of telehealth services, CHA suggests the Commonwealth should consider expanding this list to include admitted patient services delivered in non-hospital settings, and other community based services. There are many circumstances where telehealth can contribute to better admitted patient care, including to maintain an established therapeutic relationship which contributes to the patients' continuity of care; when there is a lack of alternative treating specialists (as is common in regional and remote areas); and when travel, work and family commitments and wellness barriers restrict access to attending services face to face. CHA recommends the application of these telehealth items for admitted patients under the same principles that apply to outpatients to support timely access to health services.

CHA also recognises that despite its clear advantages, telehealth and digital access are not appropriate for everyone. Even for those who prefer it, but particularly for people with health needs who are from vulnerable groups, there are still a number of identified barriers before its full benefit can be achieved. These include, but are not limited to, a lack of access to:

- a safe site for clients to receive services;
- technology, including insufficient access to data or the internet;
- equipment, technology support, and secure, easy-to-use telehealth software for service providers; and
- training for staff within service providers.

[4] RACP. 2020. Results Of RACP Members' Survey Of New MBS Telehealth Attendance Items Introduced For COVID-19. [online] Available at: <https://www.racp.edu.au/docs/default-source/policy-and-advocacy/policy-and-advocacy/racp-members-survey-new-mbs-telehealth-attendance-items-introduced-for-covid-19.pdf?sfvrsn=31d1ef1a_7> [Accessed 17 August 2020].

As such, this submission identifies the complementary need to resource these services through enhanced education and clear guidance - particularly in developing a skilled workforce, improved access to technologies and digital platforms, and developing clinical frameworks to deliver services through new formats.

This submission also acknowledges that funders also need to allow services to utilise telehealth and digital access options through their funding and service agreements.

Recommended Budget Priorities:

1. Retain MBS telehealth items and expand services to admitted patient care.

Out of Hospital Care Expansion

Out of Hospital (OOH) care is an opportunity to ease pressure on the health system and provide patients with better, and more flexible, care. Compared to traditional in-patient care for medically stable patients, OOH care can often be more efficient and effective, with lower readmission rates, shorter length of stay, and decreased rates of mortality, and increased patient satisfaction[5].

The funding mechanisms which allow the private health system to operate – specifically, Medicare and Private Health Insurance legislation – work relatively well for care delivered in a physical hospital setting, but have not kept pace with innovations in healthcare having proven unnecessarily prohibitive. Telehealth - a mode of delivering care which has been available for decades and is often of great benefit to patients - was only recently expanded through the Medicare Benefits Schedule on a temporary basis in response to the COVID-19 outbreak.

OOH care, with many parallels to telehealth, has been left behind. As a result, OOH care is underutilised in Australia, and is now often described as the 'missing sector' of the Australian health system. Without reform, OOH care will continue to be fragmented, limited and fall well short of its potential.

CHA has undertaken a review of the barriers which are holding back OOH care, and proposes a number of solutions which will allow OOH care to flourish.

Changes are required to the *Private Health Insurance Act 2007* and Medicare Benefits Schedule (MBS) to allow funding to flow. Money needs to be shifted out of expensive hospital buildings, and allocated to where it can be most effective. There is, of course, still a huge role for hospitals – but this will be expanded to deliver care through appropriate models which produce better outcomes should be the first option.

Changes are required to the governance and standards, so that we can ensure that OOH care is not the poor cousin of in-hospital care. As good as telehealth is, if all interactions between patients and doctors are reduced to phone calls, then clearly quality of care will suffer. Likewise, we need to make sure that OOH care provides high quality care in the home and that patients can trust that is what they will receive. This requires national standards, and it requires good data for tracking.

[5] Varney J., Weiland T., Jelinek G. 2014, 'Efficacy of hospital in the home services providing care for patients admitted from emergency departments: an integrative review', International Journal of Evidence-Based Healthcare, 12(2), 128-141; Caplan G., Sulaiman N., Mangin D., Ricauda N., Wilson A., Barclay L. 2012, 'A meta-analysis of "hospital in the home', The Medical journal of Australia, 197 (9), 512-19

OOH care will not grow on its own. This reform also requires teamwork and clinicians, hospitals, health funds, health departments, patients and carers need to work together to make sure the services are understood and embraced. This means the services must be expanded with the patient at the very centre of the design, and with their interests at heart.

With these reforms, there is enormous potential for OOH care to transform from the "missing" sector into a flourishing and highly effective sector which is a major contributor to health outcomes across Australia as well as the financial sustainability of our health system.

Noting the Government's commitment to this reform, commencing with at-home rehabilitation and community mental health services in 2020-21, this expansion should continue with support for more palliative care services delivered at home and other acute services being facilitated in a home environment.

Recommended Budget Priorities

2. Continue the expansion of out of hospital care, prioritising palliative care services delivered at home, by:
    a. extending the current minimum default benefit to OOH services provided by, or on behalf of, private hospitals.
    b. amending the Private Health Insurance Act 2007 to support partnerships in developing OOH models.
    c. amending funding mechanisms through MBS rebates and PHI benefits, including telehealth MBS items and episode of care-based payments.
    d. funding for successful OOH programs into large scale sustainable programs.
    e. ensuring consistency in clinical standards and regulations across OOH services.
    f. establishing a national definition of OOH for admitted and non-admitted patients to inform consistent data collection requirements across state jurisdictions.

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.[6]

CHA members form a national network of more than 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

[6] Australian Bureau of Statistics (ABS). Population Projections, Australia, 2012 (base) to 2101. Canberra: ABS.

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 four to twelve per cent die at home[7], when 50 to 70 per cent of people prefer to die at home[8]. Only one in 50 residents receive palliative care under the Aged Care Funding Instrument (ACFI). 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[9].

Economic arguments are based on the cost-effectiveness of PC with overall savings attainable different in all settings. Not only does early access to PC services impact clinical and economic outcomes for inpatients, but studies have shown cost savings of 71 percent when PC is provided within two days of hospital admission rather than six days[10].

Studies report that community-based PC is more cost-effective than tertiary care driving calls to expand community-based PC services[11]. 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[12]. 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[13]. A recent report into the economic costs of PC determined that a cost savings of $460 million per year or 12 percent could be achieved through appropriate interventions that reduce hospitalisation costs and improve the quality of a dying individual's experience[14]. 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 for hospitals. The management of data in each state jurisdiction and Commonwealth in how people record and quantify PC at various points in inconsistent. MBS data only accounts for a fraction of home and community-based PC. Until health services can understand and standardise how they collect and measure the data

[7] Productivity Commission. Introducing Competition and Informed User Choice into Human Services: Reforms to Human Services. Canberra; 2017. Report No.: 85.
[8] 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.
[9] 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.
[10] 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.
[11] 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.
[12] Senate Community Affairs References Committee (SCARC). Palliative care in Australia. Report to the Senate, Australian Government. Canberra; 2012.
[13] Silver Chain Group. Submission to the Productivity Commission's Issues Paper. Human Services: Identifying Sectors for Reform. 2016.
[14] Palliative Care Australia and KPMG. Investing to save: The economics of increased investment in palliative care in Australia, 2020.

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

CHA recognises 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 recommends 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 organisations 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. KPMG estimates that funding increases in home and community based palliative care could by fully offset by savings from decreased hospitals stays, fewer ICU days, and fewer ED presentations that result in more people dying in their place of preference.

Workforce

Across Australia, there are currently 1.0 FTE PC physicians and 12.0 FTE PC nurses per 100,000 population.[15] This indicates a significant shortage of PC clinicians to cope with the increasing needs of an ageing population. The minimum model of care recommends 6.7 specialist inpatient beds per 100,000 population, but current data indicates the use of PC services in hospitals is not adequate to support this minimum requirement. 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.

[15] 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

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.

Recommended Budget Priorities:

3. Implement 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.
4. 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).
5. 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.
6. 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 Populations with Healthcare Vulnerabilities

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.

People living with mental illness

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 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 clinically the 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 experiences 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).[16]

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. CHA calls for improved access

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

to quality health care for those seeking asylum and recommends more transparent and consistent monitoring of their ongoing health and wellbeing needs.

Alcohol and Other Drugs

Having access to alcohol and other drug (AOD) services in the right setting and at 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.

According to the best estimates, up to 500,000 Australians can't get the help they need from alcohol and other drug treatment services because they're either not available or waiting lists are too long. It doesn't matter whether someone is just starting to develop a drug problem, or whether they have a severe dependency issue, many can't get the help they need. The situation is at its worst in regional and rural Australia. This is a crisis, and it requires urgent action.

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 at 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, it is the Australian populace that bears the economic and social costs of this crisis.[17]

To address the unmet demand in Australia's treatment services, CHA believes structural reform is required in three priority areas: a) improving the size and focus of investment in the alcohol and other drugs treatment sector by updating and implementing the Drug and Alcohol Services Planning Model (DASPM); b) investing in service and workforce capability by establishing and funding an Alcohol and Other Drugs Treatment Sector Capability Fund; and c) improving coordination and governance across the alcohol and other drugs treatment sector.

In addition, following the heavy impact of the COVID-19 pandemic both on the alcohol and other drug use habits of Australians and the AOD sector as a whole, CHA proposes several additional areas for action and which complement our call for improved coordination and integration of the alcohol and other drug treatment sector. These are:

- Make permanent, build on, improve, and expand telehealth and digital access options;
- Increase access and affordability of opioid pharmacotherapies;
- Pandemic- and bushfire-related economic and job stimulus in regional and rural Australia must include investment in alcohol and other drug services;
- More efficient and frequent data-gathering and greater access to improve evidence-based decision making;
- Investment in Australia's mental health needs to include a parallel process for alcohol and other drugs.

[17] Collins, D, & and Lapsley, H, 2008, The costs of tobacco, alcohol and illicit drug abuse to Australian society in 2004/05, Commonwealth of Australia.

CHA also supports the recommendations and priority actions outlines in the *National Drug Strategy 2017-2026* that emphasise 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.[18] This requires a whole of Government response with greater cooperation and interagency support to advance this strategy.

People experiencing homelessness and insecure housing

Despite innovative partnerships among community-based housing support and health service organisations – and equally impressive efforts by state and territory governments to address the vulnerability of people experiencing homelessness to COVID-19 by providing temporary accommodation and a range of other services, given the scale of job losses and economic insecurity created by the pandemic, CHA expects homelessness and housing insecurity to worsen in the short-term.

In addition, tens of thousands more Australians will find themselves living in the shadow of homelessness as they struggle with a lack of affordable and secure housing and related challenges.

Health is a crucial piece of the homelessness puzzle: an unmanaged illness is often the factor that tips a person into homelessness or makes it difficult for them to leave it behind.

Homeless persons generally have a range of complex needs that affect potential access to safe and affordable housing. Health issues among people who are homeless invariably cluster with, and are exacerbated by other social determinants of health, including trauma, poverty, unemployment and social disconnection. This challenges traditional clinical boundaries and health system responses.[19]

Some of the major homeless cohorts are those with mental health and addiction issues, those escaping domestic violence or who have experienced significant trauma and people released from prison. Often those with acquired brain injury and intellectual disability are among the cohort.

People experiencing homelessness have more health problems, often struggling with a range of co-morbidities, and die earlier than the general population.

Physical health issues including respiratory tract infections, skin infections, poor oral and foot health, musculoskeletal disorders, and blood-borne viruses (e.g. hepatitis B, hepatitis C) are all common among people experiencing homelessness.[20] Much of this burden is thought to be related to the experience of homelessness itself, as homelessness is associated with poor nutrition, poorer access to health care, higher exposure to smoking and substance use, as well as challenges adhering to medications and treatment.[21]

[18] 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.

[19] Wood, L., Vallesi, S., Martin, K., Lester, L., Zaretzky, K., Flatau, P., Gazey, A (2017). St Vincent's Hospital Melbourne Homelessness Programs Evaluation Report. An evaluation of ALERT, CHOPS, The Cottage and Prague House. Centre for Social Impact: University of Western Australia, Perth, Western Australia.

[20] Hwang S, *Homelessness and health*. CMAJ. 2001 Jan 23; 164(2): 229–233.

[21] Hwang S, *Homelessness and health*. CMAJ. 2001 Jan 23; 164(2): 229–233.

However, it is the experience of Catholic hospital providers – many of which provide tailored services to address the health needs of people experiencing homelessness – that as important as their efforts are, if people don't have long-term accommodation with ongoing tailored support, health care alone can't end homelessness.

Health needs housing. One of the reasons homelessness is such an intractable problem in Australia is because there's an estimated shortfall of 300,000 social housing properties for people on low incomes.

CHA supports the recommendations outlined in the Social Housing Acceleration and Renovation Program (SHARP) proposal which calls on the Commonwealth to invest in delivering 30,000 urgently needed new social housing dwellings across Australia, which would not only provide an immediate boost in terms of jobs and economic stimulus but also a crucial benefit in the fight against homelessness.

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 Commonwealth to consider these issues 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:

7. 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 increasing access to community-based supports following discharge from hospital, particularly for those at high risk of suicide.
8. 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.
9. 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.
10. Improve funding and access to health services that meet the needs of asylum seekers, including more transparent and consistent monitoring of their ongoing health and wellbeing needs.
11. Government commitment to support the recommendations and priorities of the National Drug Strategy 2017-2026 in addition to:
    a. Implementation of the Drug and Alcohol Services Planning Model to improve the focus on investment in AOD services;

b. Resource an AOD Sector Capability Fund;
c. Improve coordination and governance across the AOD services sector.

12. Commonwealth investment for the 30,000 urgently needed social housing units needed across Australia and a recognition of the complex and interdependent factors that require a multidisciplinary approach to addressing these wicked problems.
13. 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 government's continuing commitment to many of the reforms identified in priority areas and looks forward to the opportunity to work with the Minister for Health and the Department of Health on the budget and reform areas identified.

Yours sincerely,

Pat Garcia
Chief Executive Officer
Catholic Health Australia

29 January 2021