

APS Response to the Australian Government Senate Select Committee on Health

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Executive summary

The APS is the national professional organisation for psychologists, with over 21,000 members across Australia. Psychologists are experts in human behaviour and use evidence-based psychological interventions to assist people to overcome ill health and optimise their health and function in the community.

This submission aims to outline the essential features of an equitable and sustainable healthcare system in Australia and outlines the impact of psychological factors (cognitive, emotional, social and behavioural) on all aspects of health. It also outlines the importance of addressing psychological factors at all levels of the spectrum of health care service delivery from health promotion and prevention through treatment to rehabilitation.

The Australian health system is beginning to acknowledge the role of psychological factors in mental health but the biomedical model of health continues to dominate the actual delivery of much of our health care and the system as a whole. This is despite the fact that it is now widely accepted that biological, psychological and social factors influence the prevention, causes, presentation, management and outcome of disease. As has frequently been noted, the most significant burden on the Australian health system is chronic disease, and many of these are greatly influenced by psychological and social factors. To develop a more effective and efficient health care system, Australia needs to adopt a biopsychosocial framework to drive health policy, administration, expenditure and on-the-ground service delivery.

Recommendation 1: That the Committee call on the Australian Government to consider the broader consequences of reduced funding for hospital and health services in terms of shifting costs onto other segments of the health budget and other sectors. In addition to financial consequences, a reduction in funding will have the greatest impact on the most disadvantaged members of the community and those with chronic and mental illness.

Recommendation 2: That the Committee call on the Australian Government to reaffirm its commitment to Medicare as the universal healthcare scheme for all Australians that provides healthcare on the basis of one's healthcare needs and not ability to pay.

Recommendation 3: That the Committee urges the Australian Government to increase funding to health promotion, prevention and early intervention to address the key contributors of the leading causes of the burden of disease in Australia. To achieve efficiencies in the health system greater access to affordable evidence-based psychological interventions to support behaviour change and address social and emotional barriers to lifestyle change is required.

Recommendation 4: That the Committee addresses problematic points of interaction between elements of the health system. This includes facilitating the ability of psychologists in the private sector to case conference with other members of the health care team; providing a fully functional PCEHR system; providing access to psychologists to improve early diagnosis and intervention for people with

dementia; and enabling residents of aged care facilities to access evidence-based psychological interventions for mental health issues.

Recommendation 5: That the Committee calls on the Australian Government to reaffirm its commitment to the Closing the Gap initiatives, including the reporting and publication of key outcomes to ensure public accountability. Funding must also be continued for the implementation of the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy (2013).

Recommendation 6: That the Committee calls on the Australian Government to ensure the sustainability of existing primary mental health care service delivery (including the ATAPS and MHSRRA programs) following the closure of the Medicare Locals.

Recommendation 7: That the Committee calls on the Australian Government to enable the delivery of evidence-based psychological services via telehealth under the Better Access initiative to people residing in rural and remote Australia.

Recommendation 8: That the Committee calls on the Australian Government to:

- Implement the ability for medical specialists to refer directly to psychologists and for cross referrals between allied health professions
- Enable GPs to refer a client for psychological services by using either a GP Mental Health Treatment Plan or a written referral letter
- Implement an MBS item number for case conferencing by psychologists to enable them to contribute to multidisciplinary health care.

Recommendation 9: That the Committee calls on the Australian Government to ensure that health workforce data collection and workforce planning is continued by the Department and includes a whole-of-workforce approach and effective stakeholder engagement.

Introduction

The Australian Psychological Society (APS) welcomes the opportunity to make a submission to the Senate Committee on Health. The APS is the national professional organisation for psychologists, with over 21,000 members across Australia.

Psychologists are experts in human behaviour and bring experience in understanding crucial components necessary to support people to optimise their health and function in the community. Psychologists work across all healthcare settings from private practice, either as independent clinicians or as member of a team of primary care professionals in a general practice, through to large tertiary hospitals. The clients of psychologists can range from young children to the elderly. A key goal of the APS is to actively contribute psychological knowledge for the promotion and enhancement of community wellbeing.

In developing this submission, the APS has taken a broad view of health and the vital role it plays in the wellbeing of not just individuals but society in general. This submission aims to outline the essential features of an equitable and sustainable healthcare system in Australia and outlines the impact of psychological factors (cognitive, emotional, social and behavioural) on all aspects of health. It also outlines the importance of addressing psychological factors at all levels of the spectrum of health care service delivery from health promotion and prevention through treatment to rehabilitation.

Principles

In order to provide meaningful feedback on Australian health policy, administration and expenditure, the APS has drawn on the work of the World Health Organisation (WHO) and the psychology evidence base to identify the following principles that underpin this submission:

- i. Equity and universality

Australia prides itself on being an egalitarian society, one where community members are tolerant and respectful of each other and are also willing to assist others in need. This principle underpins the structural foundations of the Australian healthcare system. Medicare is a universal healthcare system for all Australians funded through taxation (Medicare Levy) and provides access to healthcare on the basis of healthcare need rather than one's ability to pay for such care. This is a very successful scheme both in terms of addressing health outcomes for the general population and in terms of the scheme's efficiency. For example, while Australian government funding for health (68% of total health expenditure) is slightly less than the OECD average (72%), Australia has higher life expectancy, on average, than America and has one of the lowest rates of mortality that could have been prevented by effective and timely health care among OECD countries (OECD, 2014).

Timely access to healthcare services is another dimension of equity. The lack of timely access to healthcare services by those living outside of major population centres and those facing socio-economic disadvantage is well documented.

Therefore, any measures to improve the Australian health system must address inequity in access while maintaining the universality of Medicare.

ii. The centrality of primary health care and prevention

The WHO states that the development of effective primary health care systems is central to meeting the health needs of individuals and communities. The APS contends that, in Australia, greater emphasis needs to be placed on primary health care, including health prevention. This is for several reasons:

- Good primary health care and prevention services can delay, minimise and in some cases prevent more expensive tertiary (hospital) care and human suffering
- Primary health care and prevention services are better suited to high prevalence chronic conditions such as diabetes and produce more sustainable outcomes
- Improved primary health care and prevention services can produce more equitable health outcomes through better use of the healthcare workforce rather than relying on expensive 'hard' infrastructure such as hospitals.

iii. The role of the social determinants of health

There is now widespread recognition that health is not only determined by biological factors such as genetics, but also social factors such as employment, education and housing. In taking such an approach, there is an explicit recognition that one's health is dependent upon factors often beyond one's immediate control. The reverse is also true: by addressing such social determinants as housing, employment and education, people are in a position to better take responsibility for their own health.

iv. The role of psychological factors in health

The Australian health system is beginning to acknowledge the role of psychological factors in mental health but the biomedical model of health continues to dominate the actual delivery of much of our health care and the system as a whole. This is despite the fact that it is now widely accepted that biological, psychological and social factors influence the prevention, causes, presentation, management and outcome of disease. As has frequently been noted, the most significant burden on the Australian health system is chronic disease, many of these are greatly influenced by psychological and social factors. To develop a more effective and efficient health care system, Australia needs to adopt a biopsychosocial framework to drive health policy, administration, expenditure and on-the-ground service delivery.

Response to specific terms of reference

a) Impact of reduced Commonwealth funding for hospital and other health services provided by state and territory governments, in particular, the impact on elective surgery and emergency department waiting times, hospital bed numbers, and other hospital related care and cost shifting

The APS is concerned about the sustainability of the Australian healthcare system and the domino effect on other services (e.g., social and welfare services) should there be a reduction in Commonwealth funding for hospital and other health services provided by state and territory governments. In particular, the APS is disturbed by the announcements in the 2014 Federal Budget that included the cessation of the National Partnership Agreements on public hospital services (\$201 million) and preventative health (\$368 million), and the deferral of public dental services (\$390 million).

These cuts will inevitably translate into reduction of services, which in turn will reduce equity of access to healthcare by consumers. Delays in timely access to healthcare services mean that chronic conditions and health problems that benefit from early intervention (e.g. mental illness, diabetes) can deteriorate or exacerbate, and consequently require even more intensive and costly interventions over time. Rather than providing increased efficiencies, a reduction in Commonwealth funding may place an increased financial burden on the health system. To illustrate, individuals with chronic conditions such as diabetes that are left untreated or under-treated (due to lack of access to healthcare services) are likely to have increased risk of the long-term consequences of poor glucose control including heart attack, stroke and problems with the kidneys, eyes, teeth, feet and nerves. Similarly, many people with the early signs of mental illness, especially children and youth, who do not receive timely intervention are likely to get significantly worse both in terms of their symptomatology and their ability to function in society (e.g., education, employment, family functioning).

Reduced Commonwealth funding for hospital and other health services will not only lead to a reduction in services but also cost shifting onto other sections of the health system and sectors external to health. For example, any reduction in access to public inpatient and outpatient mental health units will see even more cost shifting to the Commonwealth-funded Better Access program than has already occurred, and has potential implications for the welfare, social service and criminal justice systems.

Recommendation 1: That the Committee call on the Australian Government to consider the broader consequences of reduced funding for hospital and health services in terms of shifting costs onto other segments of the health budget and other sectors. In addition to financial consequences, a reduction in funding will have the greatest impact on the most disadvantaged members of the community and those with chronic and mental illness.

b) Impact of additional costs on access to affordable healthcare and the sustainability of Medicare

As already indicated, Australian government expenditure on health is not excessive and sits at 68% of total health expenditure, slightly less than the OECD average of 72% (OECD, 2014).

The 2014 Federal Budget proposed a co-payment on most visits to a general practitioner (GP). The impact of this co-payment will be felt most by those in lower socio-economic areas and in rural and remote parts of Australia. For people living on Newstart allowance (\$552 per fortnight) or the Disability Support Pension (\$766 per fortnight), the proposed GP co-payment may not be affordable once rent, food and utility bills are taken into account. This may in turn lead consumers to delay or avoid GP visits and/or resort to public hospital emergency departments for conditions otherwise treatable and manageable by a GP. This increased burden on public hospitals will place even further pressures on an already over-burdened and expensive-to-run segment of the health system.

The GP co-payment measure, if implemented, will significantly undermine the principle of equity in the healthcare system, whereby consumers access services based on their need, rather than their ability to pay. This could potentially signal the end of the universality of Medicare. Previous measures such as the Medicare Safety Net do not affect consumers' ability to access healthcare in the first instance as there is no associated upfront cost. The treating GP has the discretion to bulk bill patients according to their needs and financial circumstances. However, the co-payment measure has the opposite effect. Consumers must pay the co-payment in order to see a GP. Should the GP decide to waive the co-payment, the treating GP will be subject to the loss of both the \$2 out of the \$7 co-payment as well as the \$6.60 low gap incentive. In other words, the GP will have very little discretion to bulk bill their patients due to their own financial imperatives.

Ultimately, the GP co-payment measure will increase the inequity in access to health care and increase the health outcome gaps experienced by people in lower socio-economic backgrounds and those living in rural and remote parts of Australia. It is also unlikely to reduce overall expenditure on health.

Recommendation 2: That the Committee call on the Australian Government to reaffirm its commitment to Medicare as the universal healthcare scheme for all Australians that provides healthcare on the basis of one's healthcare needs and not ability to pay.

c) Impact of reduced Commonwealth funding for health promotion, prevention and early intervention

Expenditure on prevention and early intervention is difficult to compare across countries due to differences in reporting. Expenditure on public health (prevention, promotion and protection rather than treatment) is growing in Australia and sat at 2.2% of the total health expenditure in 2007-2008 (AIHW, 2011). However, a

review of preventive health in Australia and the United States concluded that prevention in Australia is “widely viewed as undervalued and under resourced in a culture dominated by curative medicine” (Steiber, 2005, p.45).

Australia has developed some world class public health promotion, prevention and early intervention programs. Examples of such initiatives include the Life Be In It campaign from the late 1970s through to the introduction of various national cancer screening programs and the passage of the Tobacco Plain Packaging Act in 2011. All these programs required funding by the Commonwealth, either in full or in partnership with other bodies such as State/Territory health departments.

It is not specifically clear which health promotion, prevention and early intervention programs will be affected by the \$368 million cut from the National Partnership Agreement in relation to preventative health that was proposed in the 2014 Federal Budget. It is thus difficult for the APS to quantify the immediate and long term effects on population health outcomes as a result of the cuts. However, it is reasonable to conclude that any reduction in health promotion, prevention and early intervention funding will reduce access to such programs, which in turn will result in even more pressure on health budgets through increased requirements for tertiary care in the future.

According to the Australian Institute of Health and Welfare (2014) the current leading causes of burden of disease in Australia are cancer (16%), musculoskeletal disorders (15%), cardiovascular diseases (14%) and mental and behavioural disorders (13%); while diet (11%), high body mass index (9%) and smoking (8%) were the leading risk factors attributing to the overall burden of disease. It is clear that both the identified risk factors and the leading burdens of disease are best managed with a multi-pronged approach utilising primary health care settings and population health approaches. Educational programs (such as media campaigns) and regulatory changes (such as smoking legislation) are part of the solution but individuals still need assistance to implement behavioural and lifestyle changes into their own life circumstances. Lack of access to affordable evidence-based psychological interventions to support behaviour change and address social and emotional barriers to lifestyle change contributes to inefficiencies in the Australian health care system.

There is also potential for achieving greater efficiencies in the health system by investing in early intervention services. Early intervention in a range of health conditions including cancer, diabetes and mental health problems results in timely referral to health care and potentially less burden on the health care system. Without easy and equitable access to such interventions, the costs associated with the delivery of tertiary care will continue to rise, as will the burden on consumers in terms of quality of life and concomitant impact on productivity.

A reduction in Commonwealth expenditure for health promotion, prevention and early intervention may result in budget benefits in the short term, but in the medium to long term this will negatively impact on health expenditure and the broader economy.

Recommendation 3: That the Committee urges the Australian Government to increase funding to health promotion, prevention and early intervention to address the key contributors of the leading causes of the burden of disease in Australia. To achieve efficiencies in the health system greater access to affordable evidence-based psychological interventions to support behaviour change and address social and emotional barriers to lifestyle change is required.

d) Interaction between elements of the health system, including between aged and health care

Despite recent attempts to develop an integrated health care system in Australia that facilitates smooth interaction between the components of the system, this has not yet been achieved. In relation to mental health, the significant reforms to the primary mental health care sector over the last decade have dramatically increased consumer access to evidence-based psychological interventions (Pirkis et al, 2011; Whiteford, et al., 2014), but interaction between the public and private sectors with regard to the delivery of integrated patient care remains less than ideal. For example, while GPs are funded to undertake case conferencing with other health professionals, psychologists in the private sector are not financially supported to interact with health professionals in either the public or private sector. With the increasingly narrow focus of public mental health services on acute presentations and low prevalence disorders, the need for an effective primary mental health care service has become increasingly evident. Psychologists in the private sector working under the Better Access and Access to Allied Psychological Services (ATAPS) program report that they frequently receive referrals of patients from the public sector (through GPs), including on discharge from inpatient facilities. The efficiency and effectiveness of this point of intersection in the mental health system could be greatly enhanced by facilitating the capacity of psychologists to interact with the full health team around patient care. A mechanism for achieving this would be a Medicare Benefits Schedule (MBS) item number for psychologists for case conferencing.

The existence of a fully functional personally controlled electronic health record (PCEHR) would also improve interactions between the public and private mental health sectors. This would require the uptake of the PCEHR by the public mental health sector and the ability of psychologists (and other allied health professionals) in the private sector to write entries in the record. The PCEHR has the potential to significantly increase the efficiency and effectiveness of the healthcare system by increasing timely access to relevant healthcare records and coordinated care between healthcare providers. If implemented in full for all healthcare providers, the PCEHR can improve the outcome of consumers through increased participation of their healthcare, appropriate discharge planning, decreased use of duplicate diagnostics and enhanced safety and quality of care provided.

Unfortunately, the PCEHR remains largely out of reach by psychologists due to lack of investment and incentives by the Government (in contrast to general practice). Greater participation by psychologists in the PCEHR is vital to improve its

functionality and use by consumers and other healthcare providers. Specifically, the PCEHR must have a fully developed provider portal for all registered providers to view and input information to the PCEHR. This will require additional investment by the Government.

With regard to aged care, it is evident to the APS that the separation of aged care and health care has disadvantages. The separation is particularly obvious with regard to people in the aged care sector being able to access effective assessment and intervention for mental health and behavioural issues. For example, with regard to dementia, prevalence rates in Australia are expected to at least triple by 2050 (DoH, 2014). Early diagnosis and intervention has been demonstrated to reduce the need for residential care placement and to keep people with dementia living in the community longer (Prince et al, 2011). However, access to such services in Australia is limited. The primary care sector could be better equipped to undertake early diagnosis if they had access to the diagnostic contributions of clinical neuropsychologists. This would facilitate the application of sensitive measures of cognitive functioning to the investigative process; these diagnostic tools are particularly accurate very early in the disease process and can therefore provide a solid foundation for prognosis and informed treatment planning. Families and carers also have limited access to early intervention evidence-based psychological interventions that could assist them to better manage caring for the person with dementia. People with dementia who reside in aged care facilities are particularly vulnerable to the inappropriate use of chemical and physical restraints with their concomitant side effects, despite the evidence for the effectiveness of psychological and behavioural interventions (Peisah & Skladzien, 2014). Policy and funding responses that could provide access to both diagnostic and psychological and behavioural interventions for dementia, and for the carers of people with dementia, could significantly improve the effectiveness and efficiency of the health system.

Residents of aged care facilities who have a mental illness are particularly disadvantaged. They do not have access to evidence-based psychological interventions through the Better Access scheme nor through Commonwealth funding to aged care facilities. This is despite the evidence for the effectiveness of psychological interventions for mental health disorders, especially depression, in the elderly (Frazer et al. 2005).

The newly created portfolio of the Department of Social Services does represent a holistic approach to addressing some of the social determinants of health as it encompasses housing, aged care and mental health among other areas of responsibility. However, the APS is also concerned that the splitting off of aged care from health into the Department of Social Services will further widen the existing gap between health and aged care services.

Recommendation 4: That the Committee addresses problematic points of interaction between elements of the health system. This includes facilitating the ability of psychologists in the private sector to case conference with other members of the health care team; providing a fully functional PCEHR system; providing access to psychologists to improve early diagnosis and intervention for people with dementia; and enabling residents of aged care facilities to access evidence-based psychological interventions for mental health issues.

e) Improvements in the provision of health services, including Indigenous health and rural health

The WHO states that health is not simply an absence of disease but a state of complete physical, emotional and social wellbeing. Health and wellbeing are influenced by far more than the health care system, or the individual choices we make. Specifically, inequities in such factors as housing, employment, educational attainment, access to services and built environment all have an impact on one's health status. These factors are especially relevant to Indigenous people and those living outside major cities. From a policy response perspective, addressing the inequities in these social determinants must be prioritised along with frontline services such as hospitals, medical and allied health services.

The Closing the Gap initiatives are an example of addressing social inequities using a coordinated whole-of-government approach. These initiatives aim to address key measures of disadvantage among Indigenous Australian such as employment, early childhood development, education, health and economic participation, with the annual reporting of outcomes to Parliament providing a key mechanism for accountability. The APS is pleased that the Closing the Gap initiatives have not been affected by major budget cuts. However, the cuts announced in the 2014 Federal Budget to other areas of health, such as the abolition of Medicare Locals and establishment of a smaller number Primary Health Networks (PHNs) with greater geographical coverage, have the potential to reduce the overall effectiveness of the Closing the Gap initiatives. Medicare Locals (and previously Divisions of General Practice) have played an important role in delivering services to Indigenous people and improving the accessibility of general practice to Indigenous communities. A specific example of this is the ATAPS Tier 2 program that provides funding for the delivery of evidence-based psychological interventions to Aboriginal and Torres Strait Islander people. Medicare Locals are the fund holders for this program but the new PHNs are unlikely to deliver services unless they are located in areas of market failure. It is unclear how market failure will be determined and how such vital services can be sustained following the shift to PHNs.

An important aspect in improving Indigenous health is addressing the high rate of suicide that sits at twice that of the rest of the Australian population (ABS, 2012). Accordingly, the Australian Government developed a National Aboriginal and Torres Strait Islander Suicide Prevention Strategy (2013) that called for a community-focused, holistic and integrated approach to suicide prevention amongst Indigenous

Australians. Funding to support the implementation of this strategy must continue to be prioritised.

Medicare Locals have also been a major deliverer of primary mental health services (other than GPs) to rural and remote Australia. These services represent a major reform with many rural communities now having access to evidence-based psychological treatment. These services have primarily been delivered through ATAPS and the Mental Health Services in Rural and Remote Australia program (MHSRRA). These services have been especially important to more remote communities that have limited access to private providers.

The delivery of mental health services to rural and remote regions presents a challenge to the State/Territory health departments who struggle to provide a skilled and experienced workforce. It is therefore surprising that more use has not been made of telehealth to provide access to evidence-based psychological interventions under Better Access. Currently, psychiatrists in the private sector are able to provide services via telehealth (with no gap fee) to people living in rural and remote Australia. Making such facilities available to psychologists would significantly improve access to effective and efficient mental health care outside of major capital cities.

Recommendation 5: That the Committee calls on the Australian Government to reaffirm its commitment to the Closing the Gap initiatives, including the reporting and publication of key outcomes to ensure public accountability. Funding must also be continued for the implementation of the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy (2013).

Recommendation 6: That the Committee calls on the Australian Government to ensure the sustainability of existing primary mental health care service delivery (including the ATAPS and MHSRRA programs) following the closure of the Medicare Locals.

Recommendation 7: That the Committee calls on the Australian Government to enable the delivery of evidence-based psychological services via telehealth under the Better Access initiative to people residing in rural and remote Australia.

f) Better integration and coordination of Medicare services, including access to general practice, specialist medical practitioners, pharmaceuticals, optometry, diagnostic, dental and allied health services

In a review of the literature on the Australian healthcare system, the authors concluded that there is “room for improvement in most areas, and in particular in the coordination and management of primary health care, hospital services, sub-acute care and aged care services” (Hurley, 2009, p. 49). These gaps continue to be evident and represent not only inefficiencies in the system (and therefore contribute to the affordability and sustainability of the healthcare system in Australia), but more importantly, result in discontinuity of care for those seeking healthcare services.

The following are recommendations for improving the integration and coordination of Medicare services in relation to the delivery of psychological interventions:

- The MBS requires GPs to act as a referral service to psychological services, which is inefficient and costly and can lead to treatment delays. The schedule could be amended to allow direct referrals from medical specialists (e.g., physicians, paediatricians) to psychologists. This reform would create significant savings for Medicare and Australian consumers, reduce the administrative burden on GPs, and improve early intervention and treatment outcomes for consumers.
- Similarly, opening up referrals between psychologists and other allied health professionals would reduce the need for the consumer to go back to the GP for a referral, hence creating cost savings and quicker access to treatment. An example of this would be a psychologist who identifies the need for a dietitian to be involved in the management of an individual with an eating disorder, or vice versa.
- Many psychologists report considerable variability in the quality of assessments provided to them in GP Mental Health Treatment Plans (GPMHTPs) and are very often required to redo the assessment and treatment plan. Efficiencies could be made by making these Plans optional. The gatekeeping role would always rest with the GP who could provide either a full Plan, or, a simple written letter of referral (as they currently do for referrals to other health practitioners at the standard consultation rate). This approach creates efficiencies by making best use of the time and skill base of both GPs and psychologists.
- As previously indicated, coordination of mental health care would be significantly enhanced by the provision of an MBS item number for psychologists to case conference with other members of the treating team, including GPs, psychiatrists, and health practitioners in the public mental health system.

Recommendation 8: That the Committee calls on the Australian Government to:

- Implement the ability for medical specialists to refer directly to psychologists and for cross referrals between allied health professions
- Enable GPs to refer a client for psychological services by using either a GP Mental Health Treatment Plan or a written referral letter
- Implement an MBS item number for case conferencing by psychologists to enable them to contribute to multidisciplinary health care.

g) Health workforce planning

The APS acknowledges the importance of health workforce planning in order to meet the changing burden of disease, the financial burden in delivering health care, and the difficulties in providing an appropriate health workforce, especially outside major cities. The APS is therefore concerned at the possible consequences of the abolition of Health Workforce Australia (HWA) and is particularly keen to ensure that the gains made by HWA in relation to the health workforce are not lost in the transfer of operations to the Department of Health (the Department).

One of the most important actions undertaken by HWA has been the collection of quality workforce data to guide workforce capacity building and reform. HWA has conducted a number of important workforce studies and projects for the various health professions, including psychology. However, there is still a considerable amount of work to be done to improve the quality of this data collection so that it can be of assistance to workforce planners. This work must continue in order for Australia to be able to address the critical health workforce issues facing the nation and to meet the challenges of future healthcare needs of all Australians.

HWA has also been seminal in approaching health workforce reform from a whole-of-workforce perspective. That is, while much of their work has focused on the medical and nursing workforce, action has occurred across the spectrum of health professions. This has included a broad range of allied health professions and Aboriginal and Torres Strait Islander health workers. This whole-of-workforce approach is vital to build the capacity of the health workforce to meet the emerging health needs of the population, particularly in relation to the management of chronic illness. This broad focus on reform must continue.

Equally important is the comprehensive approach to consultation adopted by HWA that has enabled intensive engagement with stakeholders to ensure do-able, flexible and innovative workforce solutions. This level of consultation will need to be continued by the Department in order to achieve effective and sustainable outcomes.

Recommendation 9: That the Committee calls on the Australian Government to ensure that health workforce data collection and workforce planning is continued by the Department and includes a whole-of-workforce approach and effective stakeholder engagement.

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