

## Council of Australian Governments

The Council of Australian Governments (COAG) met on the 10 February 2006 and, as had previously been indicated, health, especially mental health, was the focus of their discussions. The Council comprised the Prime Minister, Premiers, Chief Ministers and the President of the Australian Local Government Association.

In the COAG communiqué produced after the meeting it states:

*This was an historic meeting with significant outcomes. All governments have seized a unique opportunity to work together to deliver a substantial new National Reform Agenda embracing human capital, competition and regulatory reform streams.*

*The National Reform Agenda is aimed at further raising living standards and improving services by lifting the nation's productivity and workforce participation over the next decade.*

*COAG agreed to concrete, practical initiatives in the areas of improved health services, skills recognition, infrastructure regulation and planning and a lessened regulatory burden on business.*

*COAG discussed mental health as an issue of national significance. (Communiqué, 2006: 1)*

There are three streams of the COAG National Reform Agenda - human capital, competition and regulatory reform.

The discussions and recommendations under Human Capital concentrated on the development of a healthy and productive workforce, by improving health and education outcomes. Therefore COAG agreed that all governments would commit to reform across health, education and training and encourage and support work. However the focus would be on outcomes that increase productivity and participation.

In terms of health some of the suggested outcomes that COAG wants to explore further are:

- *a reduction in the proportion of the working-age population not participating in the workforce due to illness, injury or disability;*
- *a reduction in the prevalence of key risk factors that contribute to chronic disease;*
- *a reduction in the incidence of chronic disease;*
- *increased effectiveness of the health system in achieving health outcomes;*  
(Communiqué, 2006:3)

The National Reform Agenda is to be overseen by a, yet to be established, COAG Reform Council that will replace the currently existing National Competition Council. The Reform Council will report to COAG on an annual basis in regards to the implementation of the reform agenda, which will be carried out by the States and Territories through the development of Intergovernmental Action Plans. However, "A final decision on the CRC will be subject to a business plan for the CRC, the development of IAPs, and agreement on financial arrangements under the NRA"(Communiqué 2006: 11). The Commonwealth agreed to fund States and Territories, and in some instances local Government, on a case

by case basis but this would be linked to, “*achieving agreed actions or progress measures and to demonstrable economic benefits, and would take into account the relative costs and proportional financial benefits to the Commonwealth, the States and Territories and local government of specific reform proposals.*” (Communiqué, 2006:11)

### Better Health for All Australians

COAG agreed to a \$1.1 billion reform package, over five years, to achieve better health for all Australians, with \$660 million provided by the Commonwealth and \$480 million by the States and Territories. The funding will be focused on establishing a new approach to promotion, prevention and early intervention and providing better care for

- people in the community, including in rural and remote Australia;
- older people in hospitals; and
- younger people with disabilities in nursing homes.

COAG announced the Better Health Initiative to re-focus the health system on promoting good health and tackling chronic disease. From 1 July 2006, \$500m will be spent over four years on promoting healthy lifestyles, supporting the detection of lifestyle risks and chronic disease through the Well Person’s Health Check that will be made available nationally to people aged over 45, supporting lifestyle and risk modification through referral to services that can assist people to make lifestyle changes and encouraging active self-management of chronic disease as well as improving integration and coordination of care for people with chronic conditions. There will also be new arrangements for case conferencing for people being treated for cancer through the medical benefits scheme.

To improve health and care in the community, including rural and remote COAG agreed to establish a National Health Care Call Centre at a combined cost of \$176 million over four years, with nurses providing triage. There will also be an additional \$20m over four years for mental health services to be included through the Call Centre.

COAG also agreed that there would be more timely and consistent assessments for frail older people by Aged Care Assessment Teams and simplified entry and assessment processes for the *Home and Community Care Program*, with funding from the Commonwealth of \$18 million over four years from 2006-07.

In rural and remote areas access to primary health care services will be improved through consolidation of funding in specifically identified areas with the aim to provide more services and greater flexibility. It was also determined that if rural hospitals are the best option for residential care for older public patients then the hospital will be supported to provide more age-friendly services and facilities.

Care for older patients in public hospitals is also to be improved in order to minimise length of stay, avoid re-admission and support the above proposal for residential care. This will be funded at \$150m over four years by the Commonwealth.

COAG also made a commitment to reduce the number of young people in nursing homes through a commitment of up to \$244m over five years.

In terms of the health workforce COAG supports the directions of the Productivity Commissions’ report on the Health Workforce and endorsed the National Health Workforce Strategic Framework, however further work will be made on the recommendations and related issues, to be reported on by mid-2006. States and

Territories are to provide detailed information on the number of additional student places required to address health workforce strategies along with other ways to address the problem. COAG agreed that the number of full fee paying places for domestic students will be increased from 10% to 25% and to increase loan assistance to \$80,000 for medical students. There will also be improvements made to the assessment process for overseas qualified doctors.

\$130m will go towards accelerating work on the national electronic health records system.

### Mental Health

COAG has asked for the creation of a national action plan to be ready by no later than June 2006. This is to include:

- *a renewed focus on promotion, prevention and early detection and intervention - including reducing the impact on mental health of substance abuse, including illicit drugs (such as cannabis and amphetamine-type substances) and alcohol;*
  - *getting the balance right between hospital care, community and primary care and the best type of accommodation for people who are unable to manage on their own;*
  - *improving and integrating the care system to enable the right care to be accessed at the right time, including mental health services, primary care, general practice, private psychiatric services and emergency department services;*
  - *improving participation in the community and employment, including greater use of non-government organisations and improved community-based and cross-sectoral supports for people with mental illness and their families such as supported accommodation, rehabilitation services and respite care; and*
  - *addressing structural issues such as workforce changes including the roles of different professions;*
  - *increasing the role of psychologists and other health professionals in primary care;*
  - *increasing the health workforce available to address mental health issues.*
- (Communiqué, 2006:15)*

This all sounds good but what do other groups in the community think about the COAG decisions?

The National Rural Health Alliance in their media release, *It's good that COAG is involved in health – but the devil is in the detail and in the delay* (Media Release 15 Feb 06) commented that the COAG communiqué mainly outlines future action by Governments. However,

*“People in rural and remote areas will welcome governments’ proposed action plan for mental health and the plans for getting young people out of nursing homes. It’s not clear what the review of Special Purpose Payments in health will mean for us, nor how the new Health Check for people susceptible to chronic disease will work in more remote areas ... Of particular interest to the Alliance is the proposal to ‘consolidate’ Commonwealth and State/Territory funding in nominated areas, with the agreement of the local primary care practitioners.”*

In an interview with the Australian Medical Association on the 13 February 2006, reference was made to the increase in full fee paying places. The AMA responded:

*“There’s no particular problem about people paying to have medical school places, obviously if they made the grade, they should be allowed access, and if they want to pay for it, that’s fine. But the commitment of the community, the commitment of government towards medical school training, and towards any training, needs to be through the HECS system. If we have an egalitarian society where people do well, and need a place, they should get a place based on merit, and based on their marks, and should not be based simply on their ability to pay.”*

The Doctor’s Reform Society, in their media release - *COAG’s Health Reform: What Happened To the Reform?* (Saturday, 11 February 2006) state:

*““Instead of clearly addressing the extensively documented crisis in mental health and committing to instituting the existing National Mental Health Strategy, this issue has been sent away for further discussion.”*

*“Instead of committing to instituting the recommendations of the Productivity Commission on Workforce, there was no commitment to extra HECS places for doctors or nurses and the best that can be offered is more full fee paying medical student places to produce doctors who aren’t good enough to qualify for HECS funded places.”*

*“Instead of looking at the \$10 billion over 4 years which the Federal Government spends to prop up the inefficient and expensive private health industry (through the PHI rebate), they have found a paltry \$1.1 billion over 4 years to address the problems of inadequate Aged Care, inappropriate nursing home placement of young people with disabilities, poor co-ordination of primary and hospital care, and inadequate preventive care.*

*“The fact that these multiple important issues rate only one tenth of the tax spending on private health insurance is a sad reflection of the priorities of COAG.”*

The Australian Health Care Reform Alliance commented that

*“The announcement of increased funding for primary care while also appreciated would have been received more enthusiastically if it had been pinned to a firmer declaration about the need for prevention and early diagnosis and commitment to the models of care that could achieve this goal. The major announced initiative, a Medicare item to cover the expenses of a “check up “ for Australians was proposed by the College of General Practitioners and is important but to then have COAG focus on doing so at age 45 suggest a failure to appreciate our current knowledge that preventative strategies require lifestyle and genetic issues to be tackled as early in life as possible.”*

NCOSS believes that while the recommendations have the potential to improve people’s health and are generally moving in the right direction in terms of improving people’s health, the Government seems to have ignored the fact that often it is not a matter of choice that affects a person’s lifestyle, health and well being, but the impact of the combination of a range of factors that are often beyond their control such as socio-economic status, support networks, housing, education, transport, access, equity, political decisions – the social determinants of health – and these do not appear to be addressed.

At the 6<sup>th</sup> Global Conference on Health Promotion in Bangkok, Thailand in August 2005, the participants put together a charter, The Bangkok Charter, which *“identifies the strategies and commitments that are required to address the determinants of health in a globalised world through health promotion. It affirms that policies and partnerships to*

*empower communities, and to improve health and health equality should be at the centre of global and national development.”*

The Bangkok Charter states that:

*“To make further advances all sectors and settings must act to:*

- **Advocate** for health based on human rights and solidarity;
- **Invest** in sustainable policies, actions and infrastructure to address the determinants of health;
- **Build capacity** for policy development, leadership, health promotion practice, knowledge transfer and research, and health literacy;
- **Regulate and legislate** to ensure a high level of protection from harm and enable equal opportunity for health and well being for all people;
- **Partner** and build alliances with public, private, nongovernmental organizations and civil society to create sustainable actions.”

However, since the adoption of the *Ottawa Charter (1986)*, a significant number of resolutions at national and global level have been signed in support of health promotion, but this has not always been followed by action. The participants at the Bangkok Conference forcefully called on Member States and the World Health Organization to close this implementation gap and move to policies and partnerships for action. This will require political leadership.

Lifestyle and the management of chronic disease are of course important determinants of health but COAG discussion /decisions ignore the most important determinants on our health. The COAG communiqué fails to recognise/deal with /acknowledge that our social and economic environments are the most important influence on our health. Things such as housing, transport, secure employment, enough money, a good start in life – the social determinants of health – the factors in our living conditions that affect our health throughout our life. Robust evidence has been available for years on the important role social and economic determinants have on our health but the gap between knowledge and action (government policies) has never been greater. The **WHO Commission on Social Determinants of Health** [http://www.who.int/social\\_determinants/en/](http://www.who.int/social_determinants/en/) *‘... is gathering knowledge and best practices for policy makers to develop and apply fair policies that reduce inequalities’ because, among other reasons, less than 2% of governments globally have a coherent, structured approach to address the social determinants of health.”* This is something that COAG could easily access.

NCOSS encourages the Australian, State and Territory Governments to further consider their health reform agenda and, like many other countries in the world, acknowledge that there is more to health than the individual and the individual’s choices. Health is the result of a complex set of interactions; it involves spiritual, cultural, physical and psychological aspects as well as individual, social, local, national and international decisions. There is no point in helping someone to make a healthy lifestyle choice or manage their chronic condition if the other issues that impact on their health, such as housing, transport etc, are not addressed.