Asthma Australia Submission to the Australian Government Department of Health

Primary Health Care 10 Year Plan Discussion Paper

July 2021

ABOUT ASTHMA AUSTRALIA

Asthma Australia is a for-purpose, consumer organisation which has been improving the lives of people with asthma since 1962.

Asthma is an inflammatory condition of the airways, which restricts airflow and can be fatal. There is no cure, but most people with asthma can experience good control of their condition.

Asthma affects one in nine Australians, or 2.7 million people. It has various degrees of severity (mild to severe) and affects people of all ages, from childhood to adulthood. Asthma can appear at all ages and stages of life.

Asthma Australia's purpose is to help people breathe better so they can live freely. We deliver evidence-based prevention and health strategies to more than half a million people each year. To ensure people can access effective treatments and best practice healthcare for their asthma, we work directly with people with asthma, their family and friends, health professionals, researchers, schools and governments. This way, we can ensure people with asthma are supported with education and access to high-quality information and care where they live, work and play in all stages of life.

Asthma in Australia

Asthma is one of the most common chronic conditions in Australia, with high prevalence rates by international comparison. Around 2.7 million Australians (11% of the total population) have asthma.[1] Asthma affects people of all ages.

People with asthma experience poorer health outcomes and quality of life.[2] People with asthma may live for a long period of time with its associated disability, and experience reduced participation in the workforce, school, childcare, sports and social events. Asthma is the 10th leading contributor to the overall burden of disease in Australia, and is the leading cause of burden of disease for people aged 5–14 years.[3]

In 2019, there were 436 deaths due to asthma in Australia.[4] Approximately 400 people die each year due to asthma,[5] and this annual statistic has remained relatively stable for the past ten years. Asthma mortality[6] and hospitalisations[7] in Australia are high by international standards. Hospitalisations due to asthma are costly; each emergency department presentation for asthma costs $443 on average, an uncomplicated hospital admission costs approximately $2,591 (approximately 1.5 hospital days) and a complicated admission costs $5,393 (approximately three hospital days).[8] The estimated cost of asthma in Australia in 2015 was $28 billion.[9] This equates to $11,740 per person with asthma and includes $24.7 billion attributed to disability and premature death.[10]

Introduction

Asthma Australia welcomes the opportunity to provide feedback to the Australian Government Department of Health on the Primary Health Care 10-Year Plan Discussion Paper.

As stated in our earlier submission on the Primary Health Care 10-Year Plan, Asthma Australia supports the fundamental premise of primary health care: that everyone should have access to the right care, at the right place, at the right time.[11] Reform of Australia's primary health care system is important because, as recognised in the Discussion Paper, "[t]he current health system is no longer fit for purpose". We welcome the acknowledgement that the current health system is not fit for purpose—as we consider that people with asthma are not receiving optimal preventive (both primary and secondary prevention) care through current service arrangements.

We are pleased that the Discussion Paper has also recognised that:

> *In addition to care of the already unwell, Australia's health care system needs capacity building and re-orientation to promote wellbeing, prevent illness, undertake early detection and respond with early intervention to emerging illness at a time when there is maximum opportunity to alter the disease trajectory.*

Early intervention is critical in redirecting people away from secondary and tertiary health care settings. In the asthma context, early intervention can avoid poor health in later life, including the development of chronic obstructive pulmonary disease (COPD). If asthma is well managed, subsequent additional chronic diseases can be prevented.

We welcome the acknowledgement in the Discussion Paper that improvements must be made to the health care system in respect of access to care and equity, where Australia ranks fourth and seventh (respectively) amongst Organisation for Economic Development (OECD) countries. We therefore also welcome the acknowledgement in the Discussion Paper that the challenges of the system are more acute amongst disadvantaged Australians, in particular:

> *…many Aboriginal and Torres Strait Islander people, residents of rural and remote communities, people from culturally and linguistically diverse (CALD) backgrounds, people with chronic disease, mental health conditions and frailty, and people facing socio-economic disadvantage.*

Indeed, it is such disadvantaged groups that are disproportionately affected by asthma, including Aboriginal and Torres Strait Islander people, people living in areas of lower socioeconomic status and people living in rural and remote areas.[12]

As a consumer-based organisation, we also welcome the recognition in the Discussion Paper that '[t]he current Australian health and disease demographic requires a whole-of-system reorientation to patient centred continuity of care with accessible, affordable and equitable primary health care at its heart'. A whole-of-system reorientation requires a different approach to health care, and it is on this basis that we also welcome the actions relating to social prescribing throughout the Discussion Paper. We support the premise of social prescribing, that is, the health system can play a greater part in health promotion and disease prevention, in addition to providing care and treatment for those who are ill.

We are also pleased to see that throughout the Discussion Paper there is a focus on the need for better integration between different elements of the health care system. At present, Australia's health care system is poorly integrated and fragmented, largely reflecting Australia's federal system, including Commonwealth/ State funding split of general practice and hospitals, and its hybrid private-public nature. It is therefore important to work towards establishing partnerships that bring together different health providers—and particularly State and Territory-based Local Hospital Networks/Districts—with primary care services in the same catchment areas, and enables collaborative care for individuals within those catchments to create a more holistic system of care.

Finally, we welcome the commitment to implementation of reform to the primary health care system, and the recognition that implementation of the reform should be monitored, evaluated, overseen and refined over the operational period of the Primary Health Care 10 Year Plan.

Importantly for the one in nine people with asthma in Australia, we consider that reform of Australia's primary health care system —to enable a strong focus on preventive health care and collaborative health care for individuals with chronic health conditions—will improve outcomes and quality of life for people with asthma. This, in turn, will reduce the rate of hospital presentations for this chronic condition and the costs associated with responding to such presentations.

General feedback

As outlined above, the acknowledgement in the Discussion Paper of the systemic issues with the Primary Health Care System, and the proposed response to these issues, is welcomed by Asthma Australia.

However, there is a lack of detail in the Discussion Paper as to how the sometimes-ambitious recommendations can be implemented. There is also little detail about time frames and the prioritisation between recommendations, should the Australian Government decide to implement the recommendations in stages, or accept only some of them.

Detail is also lacking with respect to many recommendations:

- On the references to telehealth: how to measure and improve the effectiveness of telehealth services, and continue to offer face-to-face consultations when required, for example with respect to spirometry.
- On the many (welcome) references to co-design: there is lack of detail about how this might be operationalised, so that there is meaningful collaboration, and what mechanisms will be put in place to ensure that there is meaningful co-design with a representative and diverse consumer population.
- Statements throughout the Discussion Paper refer to a redirection of funding without sufficient detail about or parameters around how this redirection will take place. While in some instances a redirection of funding may be appropriate, it is imperative to ensure that this will not lead to deficiencies in the part of the health system from where the funding is redirected.
- While we welcome the proposal for a more multidisciplinary workforce in line with the medical home/ neighbourhood concepts, access to General Practitioners (GPs) is an issue of concern, particularly with respect to barriers such as the length of consultation and whether such services are bulk-billed. In rural, regional and remote areas there is an additional barrier—the lack of GPs. For consumers with one or more chronic conditions, such as asthma, more needs to be done to reduce the barriers to accessing GPs, and determining whether other healthcare professionals, such as primary health nurses, should be able to provide health care with appropriate authorities and qualifications where GPs are unavailable.
- While we welcome the multiple references to the social determinants of health throughout the discussion paper, we are concerned that the acknowledgement of the significance of social determinants may not translate into practice. Governments need to prioritise additional investment for vulnerable people who may experience one or more social determinants which have a cascading impact on their health generally and their asthma specifically. This could be achieved through an application of proportionate universalism—balancing targeted and universal population health perspectives through action proportionate to the needs and levels of disadvantage in a specific population.

Not only is it important that such detailed information is made available for consultation, but the process for consultation must also be thorough. While many of the recommendations in the Discussion Paper—responded to below—are welcome, it is difficult to offer endorsement of these without the requisite information about how they may be implemented.

Recommendation 1: The Primary Health Care 10 Year Plan must include practical details on implementation of the proposed recommendations and a hierarchy for implementation. The draft Plan must also be made publicly and widely available for consultation.

Person-centred health and care journey, focussing on one integrated system: Recommendations 1 to 5

Rebalancing health expenditure

As outlined in our earlier submission, we believe that primary health care funding in Australia is too focused on the treatment of acute illness (reactive care) rather than disease prevention or health promotion (planned and systematic care).[13]

It was therefore our earlier recommendation that health expenditure is rebalanced from treatment to prevention. This is because preventive health is cost-effective and increasing expenditure on preventive health in Australia will result in significant health, social and economic benefits over time.[14] Focusing on preventive health is an important response to Australia's increasing healthcare needs and critical in addressing the health disparities faced by disadvantaged and vulnerable population groups.[15]

Treating chronic disease costs the Australian community an estimated $27 billion annually, accounting for more than a third of the national health budget. Yet Australia currently spends just over $2 billion on preventive health each year, or around $89 per person. At just 1.34% of Australian healthcare expenditure, or 0.13% of gross domestic product, Australia is ranked 16th out of the 31 countries of the OECD by per capita expenditure.[16]

Many preventive health interventions are cost-effective, allowing Australians to live longer and experience better quality lives and reduce the need to treat expensive diseases.[17] Economic evidence on preventive health interventions is growing.[18] For example, evidence shows for every dollar invested in selected public health interventions in high income countries, there is a $14 return on that investment.[19]

Currently in Australia, a number of reputable public health and consumer stakeholders are advocating for the Australian Government to jointly commit to a target of 5% of health expenditure to prevention and public health measures.[20] Health economists have suggested that, from a cost-effectiveness perspective, Australia could and probably should spend more on preventive health.[21]

However, we are concerned that Recommendations 1 and 3 discuss redirection of funding away from secondary and tertiary healthcare to primary health and prevention without detailing what safeguards, if any, will be implemented to ensure that secondary and tertiary health care services are not financially disadvantaged. There is a real risk that a redirection of funding could increase pressure on these already under resourced services and lead to worse outcomes for patients.

The Discussion Paper therefore needs to include detail about the nature of this redirection of funding, including detail of how to ensure the high functioning of secondary and tertiary healthcare during and after this redirection. It is important that telehealth services support all GP consultations, and are not limited to shorter consultations—a comprehensive consultation with a GP can help with preventing an exacerbation of illness, which in turn prevents further stressors on the health system.

> **Recommendation 2: Asthma Australia recommends a rebalancing of health expenditure from treatment to prevention, with explicit safeguards in place to ensure that any redirection of funding does not adversely affect secondary and tertiary health care services.**

Telehealth services

Asthma Australia is pleased that the Discussion Paper recognises the importance of telehealth, particularly at Recommendations 2 and 4.

Asthma Australia welcomes the introduction of MBS-subsidised telehealth during the COVID-19 pandemic. It has increased access to Medicare and to flexible, comprehensive care, particularly for those in rural and remote areas where geography is a barrier to accessing health care, and for people who have difficulty leaving their home, such as older people or those with disabilities. There

are, however, also barriers to using telehealth services, such as digital literacy, as well as access to required technology, unreliable internet access and non-awareness of the option.[22]

Asthma Australia welcomes the Australian Government's recent announcement that universal whole-of-population telehealth will now be permanent. However, telehealth is only effective if it delivers good outcomes. It is therefore important to address a number of issues in order to ensure a high standard of healthcare is maintained where consumers opt to use telehealth services in place of face-to-face services, including:

- The extension of subsidised telehealth MBS funding to longer consultations, noting that currently only consultations under 6 minutes are subsidised
- The above-mentioned barriers to accessing the service, namely: digital literacy, access to required technology, unreliable internet access and non-awareness of the telehealth option
- Monitoring and evaluating the impact on access and health outcomes with appropriate indicators of health need and consultation outcomes; and
- Identifying factors that improve telehealth outcomes.

Another issue that is important to address with respect to telehealth is understanding the circumstances in which telehealth is not suitable or preferable. For example, telehealth is not suitable for an asthma review if chest auscultation or spirometry is required. However, telehealth could be used for other asthma-related appointments, such as prescribing. A recent Asthma Australia survey of 1,263 people—regarding access to healthcare during the COVID-19 pandemic—found that a majority of people with asthma have found it difficult to have asthma appointments in person since COVID-19. Telehealth is critical in these situations to enable access to care.

> **Recommendation 3: Asthma Australia recommends actions under Recommendations 2 and 4 set out how to address current barriers to, and ongoing monitoring and evaluation of, MBS-subsidised telehealth for all people in Australia.**

Increasing accessibility and affordability of primary health care

> *"Asthma medication is expensive. GPs need to understand the financial barriers for consumers– ensuring accessible and affordable medicine is important. It should be everyone's right to breathe freely, and this shouldn't be impacted by whether or not we can afford the medication. There are many additional costs beyond the cost of the drug."* Person with asthma

In Australia, access to primary care varies and is affected by a number of factors, including geographic location and cost which act as a barrier and impacts on health service use,[23] and the social determinants of health, such as housing, education, employment, infrastructure and transport.[24] Such variation has resulted in some parts of Australia having very high rates of potentially preventable hospital admissions.[25]

In the asthma context, those people who live in areas of lower socioeconomic status or remote areas are more at risk for cost-related underuse ('non-adherence') of their medication.[26] A recent cross-sectional survey of adults and parents of children 5–17 years with asthma in Australia found that "[c]ost-related underuse was reported by 52.9% adults and 34.3% parents, predominantly decreasing or skipping doses to make medicines last longer".[27] This is particularly concerning, because underuse of cost-effective preventive treatments by people with asthma increases their morbidity and mortality. Other situation-dependent factors also influence patient adherence to

asthma management. These include convenience, efficacy, perception/knowledge of the severity of a person's condition.[28]

The accessibility of care could be increased by implementing:

- Innovative and flexible service provision options (such as eHealth and mHealth technologies) as a means of delivering information and services, particularly for those in rural and remote areas where access to services can be problematic. Such provision of service will need to address those limitations on telehealth discussed above and digital technologies, discussed further below; and
- Policies, pathways and processes that reduce the complexity and health literacy demands involved in accessing information and navigating the health system including across sectors and settings.

The affordability of care could be increased by the introduction of strategies to improve access to affordable medication, including:

- Targeted interventions to promote discussion of medicines and costs between doctor and patients, particularly young adult males;[29] supporting cost-effective prescribing of asthma medications; and, supporting patients to make informed decisions about their asthma medication that take into account medication expenses and their capacity to fund treatment[30]
- Decreasing co-payments, and fund asthma related equipment and devices (such as spacers) through the Pharmaceutical Benefits Scheme or via Primary Health Networks; and
- Ensuring that the cost of asthma medications is visible at the point of prescription, to enable patients to discuss medication expenses and their capacity to fund treatment.[31]

The affordability of care could also be increased by:

- Targeted interventions to give people a greater capacity for making choices between alternative suppliers, underpinned by transparent measures of prices and performance[32]
- Research to generate up-to-date economic data on the direct and indirect costs of chronic conditions including asthma; and
- Regulation of pharmaceutical companies that promote costly combination medications.[33]

Recommendation 4: Asthma Australia supports governance structures, policy frameworks and performance and funding mechanisms that increase accessibility and affordability of primary health care for people who experience barriers to health care.

Out-of-pocket costs for patients can be a barrier to accessing health care and can affect the ability of patients to get the care they need, when they need it. Out-of-pocket health care costs comprise a considerable portion of health spending in Australia, compared with other OECD countries, accounting for 20% of expenditure on health care in Australia, slightly higher than the OECD average of 19%.[34] By contrast, out-of-pocket costs account for only 10% of health spending in the United Kingdom, 13% in New Zealand and 14% in Canada, all of which have similar government funded health systems.

Additional personal expenses may also be incurred when accessing health care, such as travel and private health insurance premiums. The costs and patients' experiences of cost barriers vary

according to a number of factors including remoteness and socioeconomic status, highlighting gaps in access to affordable health services.[35]

Recent data points to the potential impact of patients' out of pocket spend: it is common, it is at a significant cost to individuals, and there is clear indication that it presents a barrier to care. There has also been an upward drift in out-of-pocket costs.[36] Further:

- Half of all patients, 10.9 million people, incurred out-of-pocket costs for non-hospital Medicare services[37]
- For the patients with costs, the median amount spent in the year was $142 per patient[38]
- 8% of people aged 15 years and over, or an estimated 1.3 million people, said the cost of services was the reason that they delayed or did not seek health care services when they needed them;[39] and
- Over two thirds of people (68%) had received a prescription for medication from a GP in the last 12 months. Of all people who received a prescription for medication, 7% delayed or decided against filling a prescription due to cost.[40]

Asthma Australia supports a Primary Health Care 10-Year Plan that enables universal access to health care, which is designed to be equitable in access and outcomes and helps to improve health and reduce health inequities.[41] Access to health care cannot be universal if the cost of health care is a barrier to this access for a proportion of, and some groups within, the population.

Recommendation 5: The actions under Recommendations 1–5 should maintain and strengthen universal access through Medicare, with a particular focus on health equity.

Adding building blocks for future primary health care—better outcomes and care experience for all: Recommendations 6 to 8

Preventive care through self-care

> *"We need a focus on health literacy, computer literacy and digital literacy – everyone needs the same ability to access information."* Person with asthma

Asthma Australia welcomes Recommendations 6 and 7 that go to enabling self-care and support for preventive care.

We believe that consumer education, training and support are critical to improving health literacy and self-management skills. In order to be accessible for all Australians and cater for different population groups and their needs, particularly those at risk of poor health outcomes and groups disproportionately affected by asthma and other chronic conditions, we recommend that consumer education, training and support is:

- Provided in Plain English and in social media style text, to reduce health literacy demands on people
- Provided in different languages, and with universal social media materials, for people from culturally and linguistically diverse backgrounds
- Culturally safe and appropriate; and
- Available in different formats (such as in-person, telephone, paper, web, digital).

In the asthma context, Asthma Australia calls for greater investment in consumer education, training and support to ensure people with asthma can prevent, control and effectively manage asthma. This is particularly important at the point of asthma diagnosis, to enable consumers to self-manage their condition and positively impact the broader community with their knowledge. Consumer education, training and support should focus on:

- The seriousness of asthma
- Effective self-management practices and shared decision-making
- Asthma medications and inhaler technique
- Asthma symptoms and triggers; and
- The potential to control asthma through good management, including the role of asthma action plans.

Recommendation 6: The actions under Recommendations 6 and 7 should include greater investment in consumer education, training and support.

Equitable, sustainable and coordinated care

Asthma Australia is encouraged by Recommendation 8, which goes to access to equitable, sustainable and coordinated care that meets the need of the consumer. Achieving equitable care in the Australian health system, including primary health care, requires a raft of initiatives designed to incentivise and reward equity in access to services, health outcomes and to support population groups that are disproportionately affected by asthma.

Asthma Australia supports the introduction of strategic and coordinated whole-of-government approaches to achieving greater equity in health. This could include conducting Health Impact Assessments and embracing a Health in All Policies (HiAP) approach to health care.

A HiAP approach to health care "is a way of working across government to better achieve public policy outcomes and simultaneously improve population health and wellbeing outcomes".[42] HiAP is built on the understanding that health policy "needs to engage with and mobilise agencies that have the policy levers and programs to influence action" in relation to social, economic, political, cultural and environmental determinants of health.[43] HiAP has been embraced locally in South Australia and globally through the Sustainable Development Goals.[44]

Leadership and culture: Recommendation 9

We welcome the recommendation on leadership development in primary health care, particularly the focus on consumer engagement and leadership, and make no further comment about this recommendation on the associated actions.

In respect of education and training, we note that as well as training early career health professionals, established health professionals should be re-trained in this 'reform thinking' approach.

Recommendation 7: The actions under Recommendation 9 should include a requirement for re-training health professionals in the 'reform thinking' approach.

Primary care workforce development and innovation: Recommendations 10 to 14

Workforce capability and sustainability

We welcome Recommendation 10 on building workforce capability and sustainability. In particular, we welcome the actions relating to a national workforce plan and strategy. This is particularly important for people with asthma.

There are long-standing challenges for Australia's health system that have undermined population health and wellbeing. These challenges include workforce issues such as shortages and maldistribution,[45] professional groups not working to their full scope of practice,[46] and inherent self-interests[47] and 'ongoing turf wars'.[48]

Numerous bodies have therefore called for the development of a national workforce reform strategy[49] and a health workforce plan to improve outcomes for people with chronic conditions, including asthma.[50]

Asthma Australia supports initiatives to increase access to person-centred support and care across primary care settings, such as by increasing opportunities for practice nurses and pharmacists to play a greater role in asthma care and supporting people with asthma to self-manage their condition (for example, asthma action plans, medication management, device technique). Pharmacies and pharmacists have a vital role in improving the health of all people in Australian, including access to medicines through community pharmacies.[51]

Patient navigators may also form a core part of the multidisciplinary team that care for people with chronic conditions including asthma, and help to coordinate and case manage patients and families affected by chronic conditions, with a focus on priority populations.

It is our strong view that the development of a national workforce reform strategy—that goes beyond the adequacy, quality and distribution of the workforce as it currently exists—is critical to the pursuit of outcomes-focused changes in scopes of practice and models of care to meet public need. Further, actions under this recommendation must detail specific measures for the rural, regional and remote workforce as a matter of priority.

Allied workforce and governance structures

Asthma Australia supports governance structures, policy frameworks and performance and funding mechanisms at Recommendation 11 that increase cooperation across different levels of the Australian health system, including primary health care. This includes mechanisms that build partnerships within and across sectors to support cooperation across different levels, including between:

- Primary health care providers and services
- Primary health care and secondary and tertiary care; and
- Health and other sectors, to facilitate multi-sector action to address the determinants of health.[52]

In the asthma context, current uptake of incentive payments for asthma health care are low. Low participation rates can either mean that recommended care is not being provided, or that barriers such as regulation discourage or prevent GPs from claiming the benefit in circumstances where recommended care is being provided.[53]

We support the introduction of financial incentives to reward and enable systematic, integrated service delivery or coordination between providers.

Further, actions under this recommendation must detail specific measures for the rural, regional and remote workforce as a matter of priority.

We also consider that social prescribing should be included as an action under Recommendation 11.

Workforce education, training and support

> *"The medical field put[s] you in a box without looking at your separate issues [all together], we [my husband and I] find that very frustrating … you are put in a box and that's what's wrong with you. When you have multiple comorbidities, doctors don't know what to do with you—too hard for them."* Person with asthma[54]

Asthma Australia welcomes the actions under Recommendations 12 and 13 that go to greater investment in workforce education, training and support to nursing, midwifery and other health professionals to enable them to provide holistic, person-centred care.

Workforce education, training and support are critical to improve the capacity of healthcare providers to provide holistic, person-centred care that respects and responds to patient choices, needs and values.

In respect of asthma, greater investment in workforce education, training and support could include:

- Education, support and training for GPs, primary health care nurses, pharmacists, asthma and respiratory educators, generalist physicians and nurses, and Aboriginal Health Workers and practitioners in remote, regional and metro Australia. Opportunities to train whole teams, not just individuals, should be explored to help foster collective responsibility for implementation and strengthen peer support and mutual learning;[55] and
- Education, training and support for health professionals to focus on (as identified in the *National Asthma Strategy 2018*):
    - The needs of people with asthma and the challenges of living with a chronic condition
    - Shared decision-making
    - Self-management and self-care support
    - Interpersonal communications
    - Risk communication
    - Culturally safe and appropriate communication and counselling techniques[56]
    - Asthma management and lung function testing
    - Investigating the type of airway inflammation (beyond asthma) and the right (precise) treatment for patients[57]
    - Promoting discussion of medicines and costs between doctor and patients.[58]

Actions under these recommendations must detail specific measures for the rural, regional and remote workforce as a matter of priority.

Medical primary care workforce

We welcome the actions under Recommendation 14 to encourage and facilitate greater supply and better distribution and retention of primary care medical practitioners, including in rural and remote areas. We also believe it is necessary to extend these actions to regional Australia.

Innovation and technology: Recommendations 15 and 16

Digital health is an important component of health service integration, making it easier to communicate, integrate, and appropriately share information. To date, Australia's health system has had a slow uptake of technologies.[59]

We therefore welcome the actions under Recommendations 15 and 16 that go to the development of digital infrastructure and digital readiness for consumers and the workforce. However, we believe there should be explicit reference to additional funding for all actions listed under these recommendations. This should also include more funding for telehealth, discussed above, as well as continued investment in My Health Record (to address barriers to uptake) and other digital technologies (such as eHealth and mHealth) to improve interdisciplinary communication and the appropriate sharing of information and care coordination between providers, services and sectors.

We also believe that it is important to include consumer voices in the development in such technologies, and to that end also advocate for the incorporation of co-design into the actions under these recommendations.

> **Recommendation 8: The actions under Recommendations 15 and 16 should include greater investment in the development of digital infrastructure and digital readiness for consumers and the workforce, and incorporate elements of co-design.**

Research, data and continuous improvement of value to people, population, providers and the health system: Recommendations 17 to 18

Asthma Australia welcomes Recommendation 17 on data collection, use and linkage. We note that one of the actions under this recommendation is the redirection of funding based on data. However, there should be standalone investment into data collection,[60] as well as the establishment of a national minimum data set for patients with chronic and complex conditions[61] such as asthma. This investment will in turn require education, training and support for consumers and the workforce.

We also welcome Recommendation 18 on research and evaluation in primary health care. We note that one of the actions under this recommendation goes to "a specific amount of dedicated funding for research in relation to rural and remote areas". We welcome the prioritisation of rural and remote areas, but consider that this funding could be expanded to other groups that experience barriers to the health care system, such as Aboriginal and Torres Strait Islander people, people from CALD backgrounds and people living in areas of lower socioeconomic status.

Australia must prioritise funding for equity-focused research, including with respect to chronic disease prevention. Research into chronic conditions, including asthma, should be a priority for the Australian Government. Without such investment, there will not be a significant reduction in

asthma-related hospital presentations and the cost of treating chronic disease will continue to be a burden on the Budget.

> **Recommendation 9: The actions under Recommendations 17 and 18 should include increased investment in primary health care research in Australia, with a prioritisation of equity-focused research.**

Emergency preparedness: Recommendation 19

Improving preparedness is an important aspect of strengthening Australia's preventive health system. Natural disasters are becoming increasingly frequent and severe and it is important to develop plans, tools and strategies to prevent anticipated, avoidable health impacts. However, we consider that the actions under this recommendation should also include a reference to climate change, and as part of this, references to air quality.

Events like thunderstorm asthma, bushfires, storms and flooding, and dust storms are becoming more frequent and severe as a result of climate change, as are temperature extremes and swings, and increased ground level ozone.[62] The health impacts of climate change are already being experienced across Australia and are expected to increase in frequency and severity as temperatures continue to rise. Further, the health impacts caused by climate change driven events are amplified by the social determinants of health and health inequities. Even with effective climate change mitigation actions, adaptation will be essential.

In respect of asthma, exposure to environmental hazards is both a risk factor for the development of asthma and a trigger for asthma symptoms in people who have asthma.[63] These events can trigger asthma flareups which lead to hospitalisation and even death. At the less extreme end of the spectrum, they result in mental and physical ill health, loss of income and lowered participation in social and recreational events.

It is vital that our health system is prepared to respond to the increasing frequency of these events. Asthma Australia recognises efforts to date by Australian governments to mitigate and adapt to climate change. However, there should be greater efforts to accelerate and increase mitigation and adaptation efforts, and these efforts should be reflected in the actions under the Recommendation 19.

> **Recommendation 10: The actions under Recommendation 19 should include language around climate change, and recognise that air pollution is associated with climate change.**

Implementation is integral to effective reform that delivers on the Quadruple Aim: Recommendation 20

Asthma Australia is pleased to see that the actions under Recommendation 20 recognise the importance of collaboration between the Federal Government and State and Territory Governments.

We are also pleased that this recommendation references co-design. Co-design equalises power imbalances between professionals, systems stakeholders and people with lived experience. It brings people with lived experience together with their health professionals, each contributing their own knowledge and expertise to design problem-solving activities.

We also welcome the emphasis on consumer engagement in the proposed independent oversight group that will provide advice on stepped implementation, prioritisation, evaluation and refinement of the Primary Health Care 10 Year Plan. There is growing evidence of consumer engagement in the health system, including consumer involvement as advocates and representatives across government committees. Consumers have most impact when they are partners in designing, implementing and evaluating meaningful reforms.[64] However, there is often only one consumer representative, and this fails to reflect Australia's diverse population. It is therefore imperative that there is active and equitable consumer engagement in the development and design of health care systems and services, which requires building the capacity of consumers and strengthening systems to include the voice of consumers in decision making.

Summary of recommendations

Recommendation 1: The Primary Health Care 10 Year Plan must include practical details on implementation of the proposed recommendations and a hierarchy for implementation. The draft Plan must also be made publicly and widely available for consultation.

Recommendation 2: Asthma Australia recommends a rebalancing of health expenditure from treatment to prevention, with explicit safeguards in place to ensure that any redirection of funding does not adversely affect secondary and tertiary health care services.

Recommendation 3: Asthma Australia recommends actions under Recommendations 2 and 4 set out how to address current barriers to, and ongoing monitoring and evaluation of, MBS-subsidised telehealth for all people in Australia.

Recommendation 4: Asthma Australia supports governance structures, policy frameworks and performance and funding mechanisms that increase accessibility and affordability of primary health care for people who experience barriers to health care.

Recommendation 5: The actions under Recommendations 1–5 should maintain and strengthen universal access through Medicare, with a particular focus on health equity.

Recommendation 6: The actions under Recommendations 6 and 7 should include greater investment in consumer education, training and support.

Recommendation 7: The actions under Recommendation 9 should include a requirement for re-training health professionals in the 'reform thinking' approach.

Recommendation 8: The actions under Recommendations 15 and 16 should include greater investment in the development of digital infrastructure and digital readiness for consumers and the workforce, and incorporate elements of co-design.

Recommendation 9: The actions under Recommendations 17 and 18 should include increased investment in primary health care research in Australia, with a prioritisation of equity-focused research.

Recommendation 10: The actions under Recommendation 19 should include language around climate change, and recognise that air pollution is associated with climate change.

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