AHHA Submission to the Tasmanian Government Department of Health Consultation Paper: Our Healthcare Future

January 2021

australian healthcare & hospitals association

the voice of public healthcare

OUR VISION

A healthy Australia, supported by the best possible healthcare system.

OUR MISSION

To conduct research, educate and influence the healthcare system to achieve better health outcomes, improved patient and provider experience, greater equity and sustainability.

OUR GUIDING PRINCIPLES

Healthcare in Australia should be:

Effective

Accessible

Equitable

Sustainable

Outcomes-focused.

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TABLE OF CONTENTS

INTRODUCTION

The Australian Healthcare and Hospitals Association (AHHA) welcomes the opportunity to provide this submission to the Tasmanian Government Department of Health on the Consultation Paper *Our Healthcare Future*.

AHHA is Australia's national peak body for public hospitals and healthcare providers. Our membership includes state health departments, Local Hospital Networks (LHNs) and public hospitals, community health services, Primary Health Networks (PHNs) and primary healthcare providers, aged care providers, universities, individual health professionals and academics. As such, we are uniquely placed to be an independent, national voice for universal high-quality healthcare to benefit the whole community.

To achieve a healthy Australia supported by the best possible healthcare system, AHHA recommends Australia reorientate the healthcare system over the next 10 years by enabling outcomes-focused and value-based healthcare. As described in AHHA's blueprint for health reform, *Healthy people, healthy systems*[1], this requires:

1. A nationally unified and regionally controlled health system that puts patients at the centre;
2. Performance information and reporting that is fit for purpose;
3. A health workforce that exists to serve and meet population health needs; and
4. Funding that is sustainable and appropriate to support a high-quality health system.

AHHA provides the following feedback to the consultation paper within this context.

[1] https://ahha.asn.au/Blueprint

REFORM INITIATIVE 1

RIGHT CARE, RIGHT PLACE, RIGHT TIME – A WHOLE-OF-SYSTEM APPROACH

(Questions 1 & 2)

Sustainability of the healthcare system is a significant concern given the already large proportion of Government spending directed to health. Further, growth is anticipated to be driven higher by the preference of individuals and society for more and higher quality services; wage growth within a labour intensive industry; changing disease rates, particularly the increased prevalence of chronic diseases; technological changes; the impacts of climate change and the ageing of the population.

Value-based health care offers an approach to the pursuit of sustainability, providing a patient-centric way to design and manage health systems. It is defined as the health outcomes that matter to patients relative to the resources or costs required (Porter & Teisberg 2006), with neither the outcomes or costs confined to single episodes of care, but rather a longitudinal view of a person's sequence of health care encounters being used to properly assess the outcomes realised and costs incurred. It offers a frame of reference for dialogue between stakeholders when working towards improving value delivered to a defined patient group or segment of the population. Such an approach aligns with the goals articulated in the consultation paper for care that is person-centred and outcomes-focused, to be provided in the right place at the right time.

Value-based health care is a global movement, with much that can be learned from experiences around the world. Health system leaders across Australia are also applying value-based health care in the Australian context. The Australian Centre for Value-Based Health Care (ACVBHC)[2] was established in 2018 to provide a nexus for research, implementation and the sharing of best practice value-based health care initiatives. The ACVBHC will be a useful source of expertise and experience for the Tasmanian Government in pursuing value-based health care.

AHHA's blueprint[3] to reorientate the health system to be outcomes-focused and value-based was developed through substantial consultation with, and input from, AHHA's Board, broad membership, and stakeholders across the hospital, primary and community health sectors – including clinicians, academics, policy makers, administrators and consumers. It identifies four areas of focus in enabling value-based health care:

1. Governance structures that are unified at the national and state levels, regionally controlled and put patients at the centre
2. Performance information and reporting that is fit for purpose
3. An integrated health workforce that exists to serve and meet population needs
4. Funding that is sustainable and appropriate to support a high-quality health system.

The shift in investment and focus identified by the Tasmanian Government Department of Health in the consultation paper will require coordinated action across all four areas. The *2020-25 Addendum*

[2] https://valuebasedcareaustralia.com.au/

[3] https://ahha.asn.au/sites/default/files/docs/policy-issue/healthy_people_healthy_systems_-_a_blueprint_for_outcomes_focused_value-based_health_care_1_0.pdf

to the National Health Reform Agreement, signed by the Commonwealth and all states and territories provides opportunities to facilitate this shift, e.g. through the pursuit of joint planning and funding at a local level, paying for value and outcomes and enhanced health data (Schedule C).

The agreements between the Tasmanian Department of Health and Primary Health Tasmania (the Tasmanian Primary Health Network) will be critical in ensuring the governance, data, workforce and funding models enable a person-centred and outcomes-focussed value-based health care approach.

INCREASED ACCESS TO PRIMARY HEALTHCARE

(Question 3)

To date, no comprehensive, ongoing data set exists in relation to how and why people use and access primary health care services, what occurs in individual consultations and the health outcomes that occur as a result of these services. This provides a significant challenge to understanding and then targeting efforts to facilitate increased access.

The Australian Institute of Health and Welfare is leading the development of a National Primary Health Care Data Asset. Pragmatically, scope is currently limited to general practice, but the goal should be to expand coverage to include specialists, pharmacy, allied health, dental, palliative care, community nursing, mental health, alcohol and other drugs, and maternal and child health. In the medium to longer term, AHHA supports this being developed further as a national minimum dataset for primary healthcare.

Without such a dataset, it would be appropriate for the Tasmanian Department of Health to work through Primary Health Tasmania for data sharing arrangements with general practices to inform and monitor access to primary healthcare. AHHA supports the importance of such data sharing arrangements to inform local population health and healthcare delivery. However, it is vital that patient privacy and confidentiality be retained, and general practices, other healthcare providers and patients must have confidence and trust in the integrity of the way such data is collected and reported. There should be judicious engagement with consumers about the benefits of data collection and the safeguards for ensuring their privacy.

TELEHEALTH

(Question 5)

The COVID-19 healthcare emergency has exposed critical bottlenecks and vulnerabilities within the Australian health system, and health services have had to adopt new ways to deliver care. Our experiences addressing these challenges can provide a catalyst for reimagining health care. As we move toward a post-COVID world, identifying the changes that are needed to form the foundation of a modern, sustainable and resilient healthcare system, focused on health outcomes and capable of absorbing shock will be as important as identifying the changes that are not.

As we identify in our recent publication, *Australian healthcare after COVID-19 – an opportunity to think differently*[4], the rapid expansion of virtual healthcare has meant that long awaited efficiencies, workplace flexibility and improvements in access to care are beginning to be realised.

Telehealth is often understood as referring to teleconsultations. However, there is a diversity of technologies and models of care that are being integrated in healthcare to support health system reform that is patient-centred, outcomes-focused and sustainable. To reflect this, there is a growing adoption of the term 'virtual healthcare', and we encourage system-wide attention to how virtual healthcare can be used for healthcare reform and a better health system long term.

Virtual healthcare—that is, care at a distance—is more than using telephone and video calls as a substitute for traditional face-to-face care. To limit virtual healthcare in this way is to squander the opportunity for healthcare reform and a better health system in the longer term.

An example of a new virtual model of care launched this year is RPA Virtual Hospital, which combined Sydney Local Health District's integrated hospital and community care with the latest digital solutions, as an alternative, sustainable solution to increasing demand for healthcare, and acting as a bridge between hospital specialist services and patient care in the community. A paper published by the Deeble Institute for Health Policy Research, *rpavirtual – a new way of caring*[5], describes this model, and identifies that virtual models are an essential component of future health infrastructure.

AHHA explores this in greater detail in another recent publication, *The effective and sustainable adoption of virtual health care*[6]. This paper describes the system-wide approach needed to effectively and sustainably adopt virtual healthcare, with focus on:

- **Patient-centredness**, including co-design with patients, and measuring what matters to patients;
- **Equity**, including proactive efforts to ensure affordability, equitable access to technology and digital literacy;
- **Cross-sector leadership and governance**, across jurisdictions and the primary and acute care sectors, and in partnership with industry and researchers;
- **Digitally-capable health workforce development**, prioritising team-based care and new roles needed to optimise integration of technology into health care;
- **Interoperability**, standards and quality assured technology; and
- **Funding for reforms**, including better use of data and evaluation.

There is optimism across the health sector, with willingness to embrace these technologies in care to achieve long-term health reform. Virtual care has demonstrated it can be more responsive to the needs of patients, improve clinical effectiveness and increase service efficiency. There is also strong evidence for patient and caregiver satisfaction. While not all care can be managed virtually, the co-

[4] https://ahha.asn.au/sites/default/files/docs/policy-issue/australian_healthcare_after_covid_19.pdf
[5] https://ahha.asn.au/publication/deeble-institute-perspective-briefs/deeble-perspectives-brief-no-13-rpavirtual-new-way
[6] https://ahha.asn.au/supplement-effective-and-sustainable-adoption-virtual-health-care

design of models of care with patients and clinicians, and using patient-reported measures to drive improvement and integration, will guide approaches such that virtual and face-to-face services operate synergistically.

INTEGRATION AND INTERFACES

(Questions 7 and 8)

Patients moving between services or using services concurrently may suffer due to difficulty in navigating complex and interwoven systems, lack of continuity, having issues 'fall through the cracks' and being exposed to a greater risk of inadequate care. Vulnerable patients such as those requiring a variety of health and social support services or those transitioning between these services are likely to be at greatest risk of disjointed care.

A cross-sector care simulation held with approximately 90 health systems from across Australia tested policy initiatives between the disability, aged care, community and health sectors. The report and recommendations[7] from this event will be useful in informing how integration across all parts of the health system and its key interfaces can be improved.

Person-centred, team-based models of care are an important strategy for addressing the inherent interdependency and increasing complexity of healthcare, as well as the need for priority setting and shared action with patients across settings broader than healthcare. AHHA explores this in more detail in a paper recently published, *Enabling person-centred, team-based care*[8]. This paper describes the system-wide approach to enabling team-based care, with focus on:

- **Population health planning and data driven models of care**, with practices and services engaged in this process at the local level.
- **Clinical governance**, with frameworks that span and link jurisdictional and professional boundaries, and provide local ownership and shared agreement of the care to be provided.
- **A cultural shift towards person-centred care**, with purposeful and active inclusion of the patient, family and carers as essential components of the team.
- **Person-centred data and interoperable technology**, with the use of indicators and measures embedded in clinical workflows, enabling real-time, shared goal-setting and decision-making with the patient and across sectors.
- **Investment in physical infrastructure**, creating environments where teams can share and collaborate.
- **Workforce development**, fostering capabilities such as in co-design, data analysis and quality improvement, and technology that supports team-based care, with student placements available to experience how high-functioning teams work.
- **Funding models**, which incentivise the use of indicators and measures in routine clinical practice, support participation in population health planning, and provide greater flexibility in how teams achieve the desired outcomes.

[7] https://ahha.asn.au/simulation2016
[8] https://ahha.asn.au/supplement-enabling-person-centred-team-based-care

System-wranglers (also known as care coordinators or system navigators) were also identified as important for some individuals for whom support at the interface with the health system is needed. The value of such an approach has been recognised recently with the Australian Government commitment to younger people living in residential aged care (DSS 2020). A national network of system coordinators is needed to actively engage and provide individualised support to young people living in, or at risk of entry to, residential aged care, including navigating Commonwealth, state and territory disability, health, housing and social support systems.

BUILDING HEALTH LITERACY AND SELF-MANAGEMENT

(Questions 10 and 11)

Self-management implies a focus on autonomy and actions of individuals. However, the underlying drivers and determinants of self-care capability are a range of environmental, economic and social factors that sit beyond the individual. This is recognised in a recent paper, *Self-care for health: a national policy blueprint* (Mitchell Institute 2020). Building health literacy and self-management approaches, as recognised as important in the Tasmanian Government Department of Health consultation paper, will require much broader consideration of the environments that either inhibit or enable self-care at the population level.

The paper also articulates several priority areas for action, including enabling health services to embed self-care support. This requires models of care to be re-designed such that:

- Health professionals can better support self-care – including having measures and monitoring mechanisms to assess self-care.
- The workforce has the skills and capabilities to provide self-care support across health services.
- Funding arrangements enable collaborative care (including preventive health and social care interventions) and explicitly support self-care engagement.

The importance of enabling team-based models of care described earlier in this submission is also relevant in actioning support for self-management.

THE CLIMATE CHANGE IMPERATIVE

(All questions)

Climate change increasingly affects people's physical and mental health and wellbeing, and the capacity of the health system to respond to complex challenges. Recent climate-related hazards and disasters have again highlighted this (e.g. 2019-20 bushfires, COVID-19 pandemic).

The health sector contributed to 7.2% of Australia's total carbon emissions, with major contributors being hospitals and pharmaceuticals (Malik, et al. 2018). Primary care also makes a direct contribution, but possibly more significantly, can reduce emissions by shifting care away from hospitals. This interdependence of the health system again reinforces the opportunities available through a value-based health care approach.

The health sector also has a responsibility to strengthen communities, support environment and health surveillance efforts, and support individuals with prevention and self-management strategies in response to disasters and emergencies.

Climate action can also have co-benefits, that is, beneficial outcomes not directly related to climate change mitigation. These include improved resource efficiency, improved air quality, green job creation, public health benefits from active travel and biodiversity improvements (CDP 2020).

AHHA has long recognised the impact of climate on health, including through long-term engagement with the Climate and Health Alliance (CAHA). This engagement included being a key member in the development of the 2017 *Framework for a National Strategy on Climate, Health and Wellbeing for Australians* (CAHA 2017). AHHA is also an Australian founding member of the Global Green and Healthy Hospitals (GGHH) initiative[9], and recently developed a *Climate and Health Strategy*[10] with Sydney North Health Network, considered unique in the primary care space globally.

AHHA encourages the Tasmanian Department of Health to work with all levels and sectors of government, industry, the community and the health sector to prevent and mitigate the health impacts of climate change. The increasingly recognised fiduciary duties and climate change risk governance obligations for health sector directors should also be considered.

[9] https://www.greenhospitals.net/
[10] https://sydneynorthhealthnetwork.org.au/about-us/climate-and-health-strategy/

REFORM INITIATIVE 2

DIGITAL INVESTMENT PRIORITIES

(Questions 1-7)

Despite the abundance of data, the healthcare system continues to struggle to provide value-based, person-centred care. Across all sectors, traditional human approaches to analytics and decision-making are increasingly considered less sustainable given the volumes of data, and prompt analysis and advice expected.

Artificial intelligence (AI) offers promising opportunities to improve health outcomes. AI can collect, compile, analyse and learn from big data, augmented by real-time data from patients, and create personalised and predictive feedback for individuals. It can improve diagnostics, catalyse patient adherence through engagement, and integrate with remote monitoring devices. AI can directly influence care and should be considered in the development of alternate funding models.

AI is dependent on big data. There are ever-increasing data sources that can support healthcare, including electronic health records, personal digital devices, pervasive sensor technologies and access to social network data. While data and devices are often siloed, the feasibility of health-data-sharing platforms to obtain and aggregate health data is being explored and integration being achieved.

With the convergence of data proliferation, increased computing power and algorithmic advances, new opportunities will soon become available. Advances in other sectors will rapidly influence what is possible in healthcare too.

Healthcare is already being impacted. Just in Australia, researchers are pursuing AI, e.g. for skin cancer detection, imaging, early intervention for heart attack risk, and clinical decision support to mitigate antibiotic resistance. Non-clinical and administrative uses will also be significant. Different aspects of healthcare lend themselves to being enabled by a variety of AI techniques in different ways. Models of care will need to incorporate AI through co-design. Clinician leadership is critical. Effective clinical governance will require understanding and capabilities across all levels and roles.

Further, the ethical challenges of using AI and new technology must be considered. Existing biases and inequalities must not be exacerbated. Rather, funding and care models that support the adoption of AI must be used to correct disparities.

Plans for digitisation and technology adoption need to ensure effectiveness, efficiency, equity and sustainability. Service providers that comprise smaller, independent providers (as is typically the case in primary healthcare) will likely find it challenging to adopt at the pace of larger providers/systems. The Tasmanian Department of Health must be cognisant of this to ensure advances do not contribute to shifts in the provision of care from primary healthcare to hospital care. Support will be necessary in pursuit of a value-based health care approach.

TECHNOLOGY INVESTMENT PRIORITIES

(Question 6)

In determining the technologies that best support the delivery of improved patient outcomes, structures and systems, including alternate funding models, are needed for assessing their value that recognise the rapid developments occurring in technology and data.

The discussion around value-based health care to date has largely been around organisational transformation and system design, with limited consideration of the impact of new technologies. Ultimately, new technologies are only useful if they provide better patient outcomes at an efficient cost, and this may not be easy to demonstrate in the short term.

It is difficult to balance the type of data and evidence required for current health technology assessments, which are largely based on clinical outcomes, with patient outcomes or experiences which are an important part of the 'value' assessment. This is perhaps due to difficulties in assessing the cost, which could be a substantial capital outlay versus value to the patient, as clinical evidence can take many years to become accepted as clinically reliable. In addition, data limitations exist such as inconsistencies in measuring patient reported outcomes or experience and the interplay with technology issues, patient complexity and the fact that what matters to patients might be different to clinical outcomes.

The 2020-25 Addendum to the National Health Reform Agreement, signed by all Australian and state and territory governments, provides a framework to build on existing initiatives around value-based health care, such as paying for volume and outcomes. The Addendum also provides a commitment to develop a national framework for health technology assessment (HTA) noting that HTA is an important means of delivering value to patients and the broader health system. There is broad acknowledgement amongst jurisdictions that patient reported measures are a vital component of a value-based approach to HTA; however work is still required to incorporate these measures, and value-based health care principles more broadly, into HTA in a timely manner.

In our recently-published issues brief, *Measuring value in new health technology assessments: a focus on robotic surgery in public hospitals*[11], AHHA has recommended:

- There needs to be a clear and consistent approach across governments, health services and clinicians to ensure that evidence to support the value of new technologies such as robotic surgery can be demonstrated in terms of both costs and patient outcomes.
- To determine the value of new technologies we need to ensure that patient outcomes and experiences are measured and included in datasets through standardised systems or collections.
- Data and evaluation need to be more coordinated with an open approach to collection and sharing. Current arrangements around registries are not consistent and it is not always clear who decides who has access to certain data or who decides what to collect.
- Funding models need to be re-considered and adapted accordingly to enable providers to focus on outcomes that matter to patients as well as cost efficiencies.
- Strategies need to be undertaken to ensure that clinicians are more engaged with overall hospital objectives to identify innovative new technologies and enable access through the public hospital system.

[11] https://ahha.asn.au/system/files/docs/publications/deeble_brief_no._37_-_measuring_value_in_new_health_technology_assessments.pdf

- To demonstrate value, health technology assessments must also include consideration of equity. Are the right patients receiving the right treatment? Value is only achieved across the whole health system if everyone that needs it can access it.

The paper draws on the experience of Metro North Hospital and Health Service (MNHHS) in Queensland and the processes it undertook to purchase the Mako robotic system for hip and knee replacements and how it was implemented into a major public hospital. This case study provides some insights that can potentially be adapted to funding frameworks that considers value as part of the HTA process.

REFORM INITIATIVE 3A

INFRASTRUCTURE INVESTMENT

(Questions 1-5)

The system for allocating capital for public hospitals is similar across jurisdictions across Australia, whereby regional health authorities compile a list of prioritised projects for investment, which are then amalgamated and prioritised centrally for funding. Decision making may occur in the department of health, at the ministerial level, or cabinet or treasury level.

In exploring whether capital allocation effectively funded patient access to efficient hospitals, Kerr & Henrie (2018)[12] identified that Australian systems tend to focus on hospital asset planning and replacement determined at the institution level, aligned with budgetary and political priorities, rather than being patient-centred or focused on clinical standards. They found that the systems for capital allocation did not optimise the distribution of assets to achieve the greatest community well-being or outcomes at a point in time, nor over time. Technical efficiency (i.e. outputs for a given level of inputs) was also not maximised. As such, government objectives for hospital services, including those of equitable access and sustainability, are not directly addressed within these systems.

As has been discussed through this submission, there is a need to re-design models of care to be person-centred and outcomes-focused. Virtual and team-based models of care must be part of that re-design, and investment in physical infrastructure should align.

It is also important that healthcare infrastructure is climate resilient, with capital investments prioritised, planned, designed, built and operated to account for climate changes that may occur over their lifetime (OECD 2018). This includes consideration of future demand for health services, likely physical impacts on facilities and their ability to cope with these, as well as integrated disaster plans to ensure health services can continue to operate during extreme weather events (Carthey, et al. 2009, CAHA n.d.).

[12] Kerr, R & Hendrie, D 2018, Is capital investment in Australian hospitals effectively funding patient access to efficient public hospital care? Australian Health Review 2018, vol. 42, iss. 5, pp. 501-513, https://www.publish.csiro.au/AH/pdf/AH17231

REFORM INITIATIVE 3B

WORKFORCE

(Questions 1-6)

AHHA commends the Tasmanian Government Department of Health for pursuing a 20-year health workforce strategy, *Health Workforce 2040*, taking a long-term view to shaping a health workforce that meets the needs of their population, as well as considering both the public and private sector workforces, and medical, nursing and allied health workforce.

AHHA proposes that strategies need to go beyond just the adequacy, quality and distribution of the workforce as it currently exists, to pursue outcomes-focused and value-based changes in models for care to meet public need and enable the workforce to work to the top of their scope of practice. This will require coordination of education, regulation and funding (at the national, state and territory and regional service levels) for both regulated and unregulated practitioners, and across health service environments. Again, the *2020-25 Addendum to the National Health Reform Agreement*, signed by the Commonwealth and all states and territories provides opportunities to facilitate this coordination, e.g. through the pursuit of joint planning and funding at a local level, paying for value and outcomes and enhanced health data (Schedule C).

Further, the non-clinician workforce must also be recognised in the Strategy. As virtual and team-based models of care develop further, the value from the non-clinician workforce will continue to increase. This includes roles supporting the integration of new technologies (ADHA 2020), through to roles such as peer support workers, care coordinators and system navigators.

REFORM INITIATIVE 3C

MEANINGFUL CONSUMER ENGAGEMENT

(Questions 2-4)

Experience-based co-design aims to create better quality experiences and systems of health care. It recognises experience is central to identifying goals for improvements, combining with participatory action research and design thinking such that improvements are co-designed.

AHHA has published, with the Consumers Health Forum of Australia, a freely available toolkit for Experience-Based Co-design[13]. The toolkit brings together existing resources from the UK and New Zealand, and with Australian case studies, to provide a context that will support Australian health services to utilise the approach.

ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE

(Questions 1-7)

Action is urgently needed to address the immense health disparities in health outcomes suffered by Aboriginal and Torres Strait Islander people. One component that may assist in addressing this highly complex wicked problem is strengthening the consumer voice in health service planning.

Bourke et al (2018)[14] examined institutional racism's role in creating health outcome discrepancies for Aboriginal and Torres Strait Islander peoples, and assessed the management of institutional racism in an Australian hospital and health service. They concluded that an external assessment tool can help hospitals and health services to change. Five key indicators were identified:

- inclusion in governance,
- policy implementation,
- service delivery,
- employment of Aboriginal and Torres Strait Islander people in the health workforce, and
- financial accountability.

In strengthening the Aboriginal and Torres Strait Islander voice in health service planning, AHHA encourages the Tasmanian Department of Health to consider the steps needed to ameliorate institutional racism through the co-designed development of an external monitoring and assessment matrix for their hospital and health services. AHHA has facilitated this in other states.

This is also explored in the publication, *Addressing racism to improve healthcare outcomes for Aboriginal and Torres Strait Islander people: a case study in kidney care*[15].

[13] https://ahha.asn.au/experience-based-co-design-toolkit
[14] https://www.publish.csiro.au/AH/AH18062
[15] https://ahha.asn.au/sites/default/files/docs/policy-issue/deeble_perspectives_brief_no._9_-_addressing_racism_to_improve_healthcare_outomes_0.pdf

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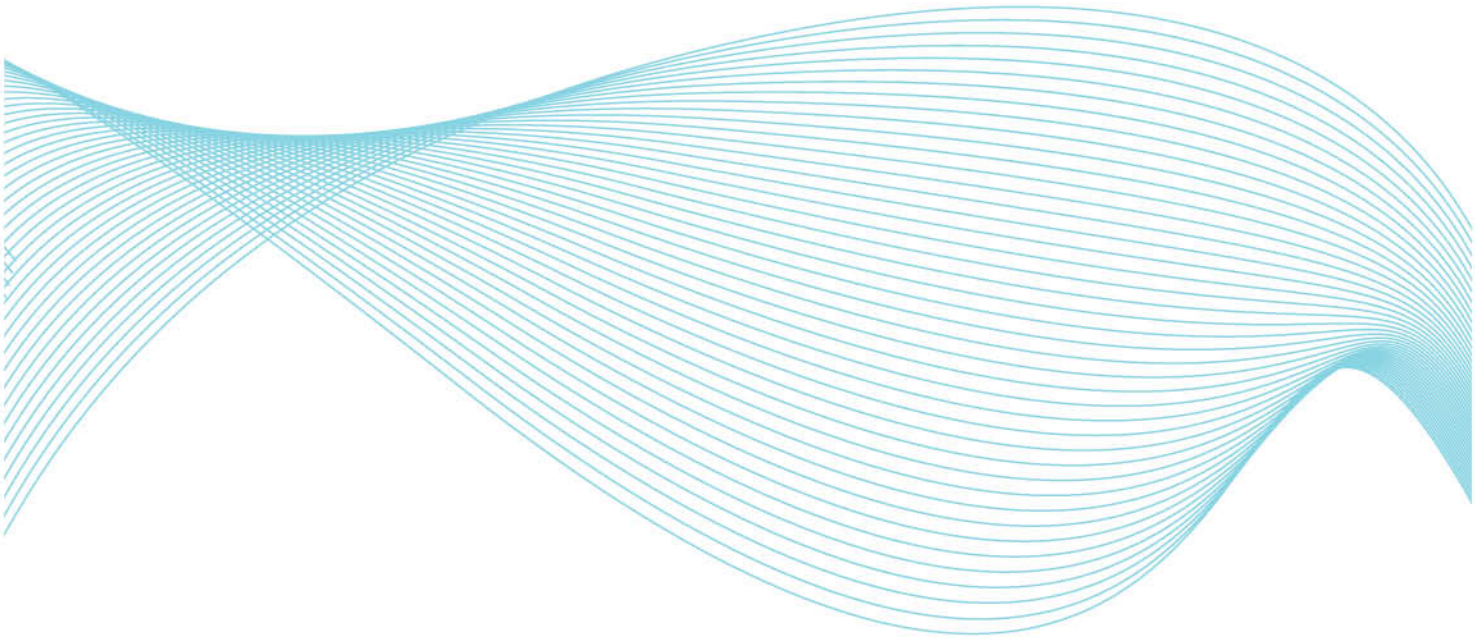

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