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2024

THIRD EDITION

GETTING AUSTRALIA'S HEALTH ON TRACK

Priority policy actions for a healthier Australia

Getting Australia's Health on Track 2024 presents a suite of evidence-informed and readily implementable policy proposals that will reduce health disparities and improve health and wellbeing outcomes in disadvantaged communities across Australia.

AUSTRALIAN HEALTH POLICY COLLABORATION

INSTITUTE FOR HEALTH & SPORT

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The Australian Health Policy Collaboration (AHPC), led by the health policy team in the Institute of Health and Sport (IHES) at Victoria University, is a national collaboration of Australia's leading population health and chronic disease experts and organisations. Established in 2014, it brings together leading health organisations and chronic disease experts to translate contemporary evidence and practice into consensus-based policy recommendations to prevent and reduce the impact of chronic diseases on the population.

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This is the third edition of *Getting Australia's Health on Track*. Previous editions, in 2016 and 2021, presented policy actions to reduce the major individual risk factors for preventable chronic disease, such as unhealthy diets, smoking, physical inactivity and alcohol consumption. This edition is focussed on policies that will benefit communities in which these risk factors cluster together, most often communities with high levels of socioeconomic disadvantage.

Ten priority policy proposals have been developed and refined through a collaborative process featuring various leading experts across the health and community sectors. The ten proposals aim to address four key policy objectives, listed below.

1. Enhanced community capability and capacity through systematic collaboration and place-based, community development

Establish a national framework and fund for local collaboration and coordination of place-based initiatives.

Establish long-term funding for community organisations and service providers.

Regenerate a community development workforce and provide support for volunteer involvement.

2. Healthier environments through the appropriate use of planning, regulation and legislation

Require and resource the development of Municipal Health and Wellbeing Plans in all state and territory jurisdictions.

Implement health and wellbeing overlays in all state and territory planning schemes.

3. Investment in tailored preventive health initiatives for disadvantaged communities

Invest in prevention through improving health literacy within communities.

Strengthen systematic collaboration between PHNs and LHNs in preventative health.

4. Equitable access to comprehensive, high-quality healthcare

Provide long-term flexible funding for coordinated multidisciplinary team-based care.

Reduce stigma and discrimination in health and community services.

Reduce financial access barriers in rural, remote and disadvantaged areas.

Glossary

Capacity building: an approach to development that builds the independence of people, organisations and communities. It aims to increase the range of stakeholders who can address problems, particularly those that arise from social inequity[1].

Community: groups of individuals who are either geographically connected and/or linked with social ties, share common interests, concerns or identities[2,3].

Community development: a holistic approach to improving the health and wellbeing of communities that emphasises the central role of local expertise and knowledge in developing community-led solutions to complex issues. Community development approaches also involve the redistribution of power to local communities, prioritise building community capacity and capability and tend to have long-term outcomes[4].

Consumer: in the health sector, consumer refers to anyone who has a lived experience of a health issue. This includes all individuals impacted by health policies, those who utilise health services, or who have a health condition, as well as their families, caregivers, and friends[5].

Co-design: an iterative and participatory engagement process in which policymakers, consumers and other relevant stakeholders work collaboratively to develop and implement health policy solutions. Existing definitions of co-design can vary slightly, however they consistently emphasise a process of active (rather than passive) consumer participation in creating mutually acceptable outcomes[6–8].

Disadvantaged communities: in the context of this report, disadvantaged communities refers to communities experiencing high levels of socioeconomic disadvantage. These communities may also be referred to as 'underserved', 'hardly served' or 'marginalised' to better capture the broader context.

Entrenched disadvantage: refers to persistent, long-term and often multigenerational disadvantage experienced by communities and individuals across a range of social and economic measures[9,10].

Health literacy: the capacity for people to access, understand and use health information in ways that benefit their health[11].

Health literacy environment: the people and elements that make up the health system and have an impact on how people access, understand and apply health-related information and services. This includes the health system infrastructure, policies, processes, materials, people and relationships[12].

Local Hospital Networks (LHNs): an organisation that provides public hospital services in accordance with the National Health Reform Agreement. The term 'Local Hospital Network' is a national term. Some states and territories use their own local terminology to describe these networks, such as local health districts, health organisations, and hospital and health services[13].

Place-based approaches/initiatives: programs designed and delivered in a specific location with the intention of targeting that location or a specific group. They are often designed to address complex problems, particularly in areas of entrenched disadvantage[14].

Primary care: generally the first service people go to for health care outside of a hospital or specialist. It includes diagnosis and treatment of health conditions and long-term care. Primary care includes general practice, Aboriginal Community Controlled Health Services, community health centres, community pharmacies, community nursing services, dental services, mental health services, drug and alcohol treatment services, sexual and reproductive health services, maternal and child health services and allied health services[15].

Primary Health Networks (PHNs): independent organisations, funded by the Australian Government to coordinate primary health care in their region[16].

Socioeconomic advantage/disadvantage: is described "as a measure of people's access to material and social resources, and their ability to participate in society"[17].

Socioeconomic status (SES): describes the level of socioeconomic advantage/disadvantage experienced by an individual or community. Socioeconomic status is influenced by range of factors including income, education, employment, occupation and housing characteristics[18].

Specialist care: healthcare provided by a specialist, a medical doctor who is an expert in a specific area of medicine. For example, someone with a heart condition might see a cardiologist, a mental health condition may see a psychiatrist or diabetes may see an endocrinologist.

Systems thinking: a cognitive framework used to analyse and understand complex systems by focussing on the interrelated parts, boundaries and perspectives within a system[19].

Volunteer-involving organisations (VIOs): organisations that involve and provide opportunities for volunteering as part of their operations[20].

Introduction

***Getting Australia's Health on Track* is a key publication of the AHPC and presents a limited suite of priority policy actions that will support measurable improvements in the health risks for preventable chronic diseases in the Australian population.**

The first two editions of *Getting Australia's Health on Track* (2016 and 2021) focussed on the major individual risk factors for chronic disease, such as unhealthy diets, high smoking rates, physical inactivity and alcohol consumption.

This third edition, *Getting Australia's Health on Track* 2024, focusses on the contemporary evidence that major risk factors often cluster together, particularly in communities with high levels of socioeconomic disadvantage. Many of these communities are affected by long-term, entrenched disadvantage and by a lack of resources and infrastructure compared to communities with low levels of socioeconomic disadvantage[21,22]. These disparities are exacerbated by top-down, disconnected policies, funding and service provision that add complexity to disadvantage for these communities.

HEALTH IMPACTS OF SOCIOECONOMIC DISADVANTAGE

Socioeconomic disadvantage is strongly correlated with poorer health and wellbeing outcomes[23]. Australian communities with greater levels of socioeconomic disadvantage have disproportionately high rates of preventable chronic disease and premature mortality[23]. These health disparities between the least and most socioeconomically disadvantaged communities are persistent and increasing. The widening gap is marked by a steepening social gradient, that is, the more disadvantaged a community is, the more likely the individuals living within the community will have poorer health and be at risk of dying earlier[24,25].

Health and wellbeing are closely linked with the settings in which people live, work, play and age. Social, structural, economic, cultural and commercial factors are often outside the control of individuals and can significantly influence health and wellbeing[26]. These factors, among others, are referred to as the wider determinants of health[26]. The social and economic factors of most relevance to the health impacts of disadvantage include income levels, educational attainment, employment opportunities, housing quality and stability, stigma and discrimination in health settings and access to resources and services[27,28]. The wider determinants of health often underpin the major risk factors for chronic conditions, particularly high levels of physical inactivity, unhealthy diets and obesity, smoking and tobacco use, and alcohol consumption[23,26,29].

Geography and socioeconomic disadvantage

Communities experiencing either very high or very low levels of socioeconomic disadvantage tend to cluster together across Australia. The 20% of Australian communities with the lowest levels of disadvantage are concentrated in proximity to major cities and some coastal regions, while the 20% that are most disadvantaged are predominantly located in regional, rural and remote areas[27].

People in rural, regional or remote areas generally have higher rates of social disengagement, service exclusion and economic exclusion compared to those living in the inner city[30]. Furthermore, socioeconomic disadvantage in regional, rural and remote areas is more likely to become entrenched within the community and persist across generations[31].

Priority population groups and socioeconomic disadvantage

Population groups who experience disproportionately high rates of chronic disease and poorer overall health are identified as priority population groups in *Getting Australia's Health on Track 2024* (and public policy more broadly). The National Preventive Health Strategy 2021-2030 identifies priority populations as including[32]:

- Aboriginal and Torres Strait Islander people;
- culturally and linguistically diverse (CALD) populations;
- lesbian, gay, bisexual, transgender, intersex, queer, asexual and/or other sexuality and gender diverse people (LGBTIQA+);
- people with mental illness;
- people of low socioeconomic status;
- people with disability; and
- rural, regional and remote populations.

It is important to note that reasons for disadvantage are not independent from each other. Interconnections between race, gender, socioeconomic status and other

factors influencing disadvantage are well recognised and described as intersectionality to recognise that causes of disadvantage overlap and often people experience multiple forms of disadvantage simultaneously[32]. This can amplify the impact of disadvantage[33].

Preventive health initiatives in disadvantaged communities

Population-wide preventive health initiatives often yield poorer outcomes in disadvantaged communities compared to other, less disadvantaged Australian communities[34,35]. This is largely attributable to access barriers and fewer resources and infrastructure being available in communities with higher levels of disadvantage[36]. Preventive health initiatives aimed at reducing risk factors for poor health and preventable chronic disease in disadvantaged communities and priority population groups need to be purposefully designed to reach, engage and be effective in these groups and communities[37–39].

Despite multiple initiatives and policies aiming to improve Australian's economic, social and community wellbeing, disadvantage is becoming more entrenched[40,41]. In response to persistent disadvantage, governments, service providers and community organisations are increasingly implementing place-based initiatives to address health disparities[41,42]. To be effective and sustained, these initiatives should feature system-wide and multi-sectoral collaboration. They require a comprehensive understanding of the various system-level factors that prevent disadvantaged communities from maximising the benefits of population-wide preventive health interventions and from building community capacity to address health risks[43,44].

THE POLICY CONTEXT

Recent national policy documents and initiatives have highlighted the need to address equity in health and wellbeing, these are summarised below.

Measuring What Matters, Australia's first national wellbeing framework aims to track progress "towards a more healthy, secure, sustainable, cohesive and prosperous Australia"[45(p3)]. Inclusion, equity and fairness are identified as central to the Framework, including a focus on reducing health disparities and levels of entrenched disadvantage. The Framework supports place-based approaches with community-led decision-making to build community capacity, ensure local needs are being addressed and integrate services by working across silos within communities. Place-based approaches can complement nationally coordinated policy frameworks, with better alignment of existing policies and programs, maximising the impact of government investment. The Framework intends to embed expanded wellbeing metrics into government decision-making and particularly "in areas of policy that require different levels of government to work together"[45(p94)].

Working Future: The Australian Government's White Paper on Jobs and Opportunities recognises that entrenched disadvantage can result in labour market inequalities and that these link to poorer health outcomes, housing insecurity and reduced social participation. The white paper states that place-based approaches which identify local priorities and coordinate resources are able to make meaningful, long-term improvements to entrenched disadvantage. The paper recognises that communities require support to implement local solutions, including involvement of local community organisations, access to appropriate local data and fit-for-purpose funding arrangements. 'Partnering with communities' is included as a priority policy area and encompasses strengthening place-based initiatives by better aligning programs across governments and expanding the role of communities in decision-making[46(p149)].

The Entrenched Disadvantage Package of the 2023-24 Australian Government Budget provides $199.8 million in programs and initiatives to improve child and family wellbeing through tackling intergenerational disadvantage. The package provides support for place-based partnerships to produce "co-designed solutions that address community needs and aspirations, including support for local initiatives that drive better outcomes in education and employment, child and maternal health, youth justice, and participation". It aims to coordinate partnerships with community, social enterprise and funders, to enhance shared decision-making and improve community outcomes[47].

The National Preventive Health Strategy 2021-2030 (NPHS) aims to deliver a strong national prevention system to improve the health and wellbeing of all Australians[32]. It emphasises that a whole-of-government approach to preventive health action, underpinned by multi-sector collaboration and strong community partnerships, is central to achieving a healthier Australia. The NPHS also features a strong focus on achieving health equity in priority population groups and addressing the wider determinants of health, including the socioeconomic factors that contribute to poor health in disadvantaged communities. It highlights the disproportionate burden of disease experienced by priority population groups and sets specific targets for improving life expectancy in rural, remote and disadvantaged communities across Australia. The NPHS states that accelerated action particularly in addressing tobacco use, nutrition and physical activity would significantly decrease the overall burden of disease in Australia[32].

GETTING AUSTRALIA'S HEALTH ON TRACK AND AUSTRALIA'S HEALTH TRACKER

A wide range of health policy initiatives, over time, both nationally and in states and territories, have aimed to reduce modifiable risk factors for preventable chronic disease. Despite these efforts, high rates of chronic disease and associated risk factors persist in the Australian population, particularly in socioeconomically disadvantaged communities. These have been highlighted in the AHPC signature report card, *Australia's Health Tracker* (2016[48] and 2019[49]). The clustering of these modifiable risk factors in disadvantaged communities has been emphasised in *Australia's Health Tracker by Socioeconomic Status* (2017[50] and 2021[51])

To help accelerate action to achieve improvements in modifiable risk factors, the AHPC developed national health targets and indicators for those risk factors that contribute most to preventable chronic disease[52]. Published in 2015 and updated in 2019, the targets aligned with the World Health Organization (WHO) *Global Action Plan* targets for reduction in preventable chronic disease (non-communicable diseases) by 2025. The WHO has since extended the *Global Action Plan* to 2030[53].

Australia's Health Tracker: Chronic Conditions by Socioeconomic Status, published with this policy paper, highlights the prevalence of chronic diseases within Australian communities by socioeconomic status. It shows that over 10 million people living in the 40% of Australian communities with the highest levels of disadvantage are at significantly greater risk of preventable chronic disease and poor health. These communities have higher rates of heart disease, stroke, cancer, diabetes, chronic obstructive pulmonary disease, mental illness, suicide and premature death than the least disadvantaged 40% of communities in Australia[24,25]. The report card shows clearly that the disparities between the least and most disadvantaged communities are persistent and increasing.

***Getting Australia's Health on Track* publications were developed to simplify, for policy-makers and others, the array of evidence and the diversity of recommendations of many of the former and existing chronic disease and prevention strategies.**

Getting Australia's Health on Track 2016 proposed 10 policy priority recommendations that would be effective in reducing risk factors for preventable chronic diseases and contribute to better health across the population. These recommendations took an individual risk factor approach, focussing on areas including smoking, dietary intake, physical inactivity and biomedical risk factor screening[54]. *Getting Australia's Health on Track* 2021 updated those recommendations, included additional policy actions and further highlighted the health inequities related to socioeconomic disadvantage[55].

The overall suite of targets and priority policy recommendations to achieve them comprises:

- Halt the rise in obesity:
  - Introduce a 20% health levy on sugar-sweetened beverages and protect children and young people from unhealthy food and beverage marketing.
- 30% reduction in average salt intake:
  - Reduce salt content in processed foods and promote potassium as a sodium substitute.
- 20% reduction in harmful use of alcohol:
  - Implement consistent volumetric tax on all alcohol products and increase the current taxation rate; restrict late supply and concentrated supply of alcohol and invest in development and evaluation of evidence-based school-based prevention programs.
- Reduce smoking to 5%:
  - Re-invest in mass media information and expand smoking cessation supports to maintain and further reduce smoking rates, particularly among priority population groups and communities with continuing high rates of smoking.
- 10% reduction in physical inactivity:
  - Implement a national physical activity plan, invest in active travel and walking infrastructure for all ages and abilities and enhance access through a voucher scheme.
- Improve mental health and halve the employment gap for people with mental illness:
  - Include physical health checks in all mental health care plans and establish sustainable national vocational programs for people with moderate and severe mental illness.

- Reduce premature death rate to 166 per 100,000 people and rates of hypertension by 25%:
  - Establish systematic screening for biomedical risk factors.

These targets are yet to be achieved. Several, such as the 5% national average daily smoking rate, are consistent with goals established in national and/or state and territory policy initiatives, while others are yet to have policy action.

GETTING AUSTRALIA'S HEALTH ON TRACK 2024 – A SYSTEMS FOCUS

Getting Australia's Health on Track 2024 adds to the suite of proposals that address modifiable risk factors individually by considering the community environments in which higher rates of these health risk factors cluster. Predominantly, these are geographical communities with high levels of socioeconomic disadvantage and priority population groups.

Historically, different levels of government, government agencies, health and community organisations and other key stakeholders have tried to address complex health issues with linear and/or siloed solutions[56]. Disadvantaged communities are often recipients of multiple policies and programs, from national and state and territory governments, not-for-profit organisations and philanthropic organisations, intending to address socioeconomic disadvantage and its impacts – and these are rarely planned or delivered to be complementary, coordinated or consistent with individual community needs[57].

Complex interactions such as these – the clustering of health risk factors, the complex layering of government and other stakeholder organisations and of policies, funding and services – are now recognised as contributors to disparities[58]. Systems thinking is increasingly being used to investigate ways to overcome this. The Australian Prevention Partnership Centre describes systems thinking "as a way to make sense of a complex system that gives attention to exploring the interrelated parts, boundaries and perspectives within that system"[19].

There is growing support for policy attention to address Australia's socioeconomic and geographical health disparities, and an expanding evidence base demonstrating that place-based solutions and community leadership are the best way to achieve this[59,60]. For disadvantaged communities, policy priorities should be to optimise the benefit of available resources and to minimise the impacts of disadvantage on health and wellbeing of people within these communities.

For these reasons, this edition of *Getting Australia's Health on Track* 2024 has used a systems approach to consider what policies and funding arrangements, at all levels of government, could be improved or changed to minimise fragmentation, duplication, waste and inefficiency and to optimise the support of coordinated, collaborative solutions tailored to the needs and circumstances of individual communities[61].

Together, the three editions of *Getting Australia's Health on Track* provide a concise consideration of relevant evidence with detailed analysis by many Australian experts of policy interventions to reduce preventable chronic disease, improve health outcomes and address health disparities. They provide a compelling case for policy action, by all levels of government, that is feasible, implementable affordable and essential, if the stated policy objectives of governments in Australia are to be met.

Project process

The expert working groups were established and comprised some of Australia's leading experts across the health, community, local government, research and policy sectors. Each group focussed on one of the three system levels of policy, investments and services that directly influence and impact on local communities. These are:

- **Macrosystem level** – the context and roles of national-level overarching structures, policies, and societal influences (e.g. Federal, state and territory governments and associated agencies, Australian Health Minister's Advisory Council, Private Health Insurers).
- **Mesosystem level** – the context and roles of organisations and institutional structures operating at a regional level across multiple local communities (e.g. PHNs, LHNs, regional organisations, professional and industrial bodies, not-for-profit and advocacy organisations).
- **Microsystem level** – the context and roles of local communities and their stakeholder groups and organisations (e.g. Local governments and related agencies, consumer and community organisations, health and community service providers).

Contributing experts who participated in these working groups are acknowledged at the beginning of this report.

Expert groups first considered the relevant system-level policy and infrastructure barriers and enablers that impede the capacity of communities to benefit from preventive health measures and that are within the capacity of policy makers to improve, change or remove. The iterative process used for the project placed the microsystem level at the centre of the process. Policy and infrastructure barriers and enablers identified as most significant in evidence and by the microsystem group were then considered by the mesosystem and macrosystem working groups.

Compiled summary outcomes of each group's discussions then formed the basis for the next phase, led by the microsystem group, which identified evidence-based policy options that will improve population health outcomes and have the greatest impact for disadvantaged communities.

A system integration group, comprising the chairpersons of the 3 working groups and the project team, synthesised the considerations and outcomes of each phase of the work to develop the complementary suite of recommended policy proposals in this report.

4

Equitable access to comprehensive, high-quality healthcare

Reduce financial access barriers in rural, remote and disadvantaged areas.

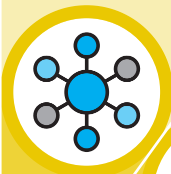
Reduce stigma and discrimination in health and community services.

Provide long-term flexible funding for coordinated multidisciplinary team-based care.

1

Enhanced community capability and capacity through systematic collaboration and place-based, community development

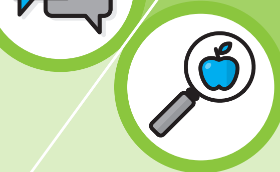
Establish a national framework and fund for local collaboration and coordination of place-based initiatives.



Establish long-term funding for community organisations and service providers.

Regenerate a community development workforce and provide support for volunteer involvement.

Strengthen systematic collaboration between PHNs and LHNs in preventative health.



Invest in prevention through improving health literacy within communities.

3

Investment in tailored preventive health initiatives for disadvantaged communities

Require and resource the development of Municipal Health and Wellbeing Plans in all state and territory jurisdictions.

Implement health and wellbeing overlays in all state and territory planning schemes.

2

Healthier environments through the appropriate use of planning, regulation and legislation

Policy objective 1: Enhanced community capability and capacity through collaboration and place-based, community development

Place-based and community development approaches that include a focus on developing community capacity and capability are highly relevant to addressing the health impacts of disadvantage as they support self-determination and empower community members to challenge inequitable conditions[4,86,87]. Such approaches emphasise the central role of community expertise in developing locally tailored solutions and the redistribution of power back to local communities[1,62]. However, a lack of cohesion and coordination across policy and practice in place-based approaches can hamper their effectiveness[57]. Various issues regarding the implementation of place-based initiatives have been reported, including: lack of a local 'glue' to support coordination and collaboration; significant demands on community sector organisations to participate without sufficient resourcing; exclusion of some service providers; poor coordination between levels of government and lack of capacity to collect, analyse and report on local data[57].

Poorly coordinated, siloed implementation of place-based initiatives leads to programs and interventions being delivered ***to*** communities rather than ***with*** communities.

Current policies and approaches are increasingly recognising the need to support community capability and capacity to develop and implement place-based, community-led solutions appropriate to the local context. This includes various place-based and community development approaches.

Policy objective 2: Healthier environments through appropriate use of planning, regulation and legislation

Healthier environments enable communities and individuals to reduce their exposure to chronic disease risk factors and achieve the best possible health outcomes. Building healthier environments cannot be achieved solely through national health policy – it requires a coordinated approach between all levels of government and across all sectors that directly or indirectly contribute to population health and wellbeing. This includes sectors such as social and community services, infrastructure, urban planning, housing, transport and education, and highlights the need for state and territory, and local governments to use the levers they have available to them to support healthier community environments.

Local governments play a pivotal role in shaping the health and wellbeing of their communities through their statutory responsibilities, including town planning, waste management, and local infrastructure[63]. These responsibilities are determined by state and territory legislation, defining the scope of local government functions within each jurisdiction[64]. Historically, the role of local governments has been primarily focussed on delivering essential services, but there is growing recognition that this should be expanded to also include responsibilities related to improving health and wellbeing in local communities[65].

Policy objective 3: Investment in tailored preventive health initiatives for disadvantaged communities

Preventive health initiatives aim to reduce the risk of developing ill-health by creating systems and environments that support people to live healthy lifestyles[66]. National preventive health initiatives are less successful in disadvantaged communities[32,34,35,125]. The NPHS 2021-2030 highlighted that while population-wide initiatives are necessary, they must be complemented by additional support through tailored, co-designed approaches for those who experience the greatest inequity[32].

Local health stakeholders (e.g. PHNs, LHNs, service providers, consumers) should work collaboratively to ensure preventive health programs and policies are fit-for-purpose and contextually relevant. Greater collaboration between these stakeholders would reduce duplication, enhance coordination and facilitate the exchange of local knowledge and expertise to effectively tailor programs and policies.

A lack of health literacy can contribute to challenges with engaging in preventive health activities, and this can exacerbate underlying health inequity and access issues for individuals[68,69]. Systemic and socioeconomic barriers in disadvantaged communities often lead to lower rates of health literacy in disadvantaged communities[32]. By improving health literacy and tailoring preventive initiatives to the local context, these communities can benefit more from preventive health programs and policies.

Policy objective 4: Equitable access to comprehensive, high quality healthcare

While Australia has arguably one of the best health systems in the world, inequitable access to comprehensive, timely and affordable healthcare, across primary, specialist and acute services, continues to drive geographical and socioeconomic health disparities[70,73].

Medicare theoretically makes access to acute care universal, however, geographical access barriers remain for many people living in rural and remote communities[73]. Medicare also aims to improve affordability of primary and specialist care through subsidising a wide range of services, but access is still heavily influenced by individual capacity to pay[162]. Australians with private health insurance (PHI)[70] (~50%) can, for a fee, access private-sector health services. The remainder of Australians without PHI have longer wait times for health services in the public system[70]. Gap payments, fees on top of the allocated Medicare Benefits Schedule (MBS) payment for a service, also make some services inaccessible to people who cannot afford the cost. A recent survey by the RACGP found that gap payments for GPs are at an all-time high[72].

Service availability and access to healthcare, particularly specialist and allied healthcare, is limited in regional, rural and remote areas[73]. This is due to geographic spread, limited infrastructure and higher costs of delivering healthcare in remote areas[73]. One contributing factor to these access inequities is the high turnover of the rural and remote health workforce, and heavy reliance on locums to fill workforce gaps, which also impedes continuity and coordination of care[73,74,75].

POLICY OBJECTIVE 1

Enhanced community capability and capacity through systematic collaboration and place-based, community development

Local collaboration and coordination

National frameworks are vehicles to provide national leadership to significant public policy concerns that involve all levels of Australian governments[76]. National health policies, strategies, plans and frameworks are widely used by governments across the world addressing health challenges, varying across countries due to political and socioeconomic contexts. National frameworks can support collaboration and align stakeholders' and community priorities to improve resource use and drive long-term, sustainable health improvements[77].

In the UK, national service frameworks have provided ten-year strategies to improve specific areas of health and social care through the National Health Service (NHS)[78]. In Australia, national frameworks have been established across a range of public policy issues, including protecting Australia's children; children's learning; Aboriginal and Torres Strait Islander communities and services; environmental management and others[79].

A national framework for community development should be established to provide an overarching structure to guide the development and implementation of policies, funding and services to support communities. It should provide guidance on collaboration and coordination within communities. The framework should be implemented together with a national funding program to provide for needs-based support and investment in community development coordination arrangements and mechanisms within disadvantaged communities throughout Australia[80]. The national fund should include Australian government funding together with state and territory government contributions.

THE PROBLEM

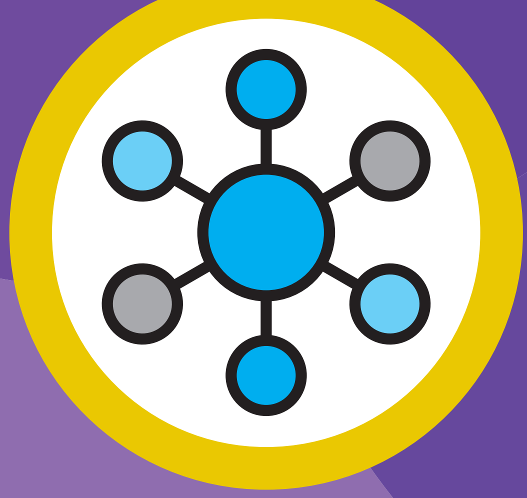
Fragmentation of place-based initiatives: Place-based initiatives are being delivered and supported by national, state and territory and local governments and in some cases by philanthropic funding. Often, multiple programs are being delivered in the same areas with little visibility of each other[42]. The potential to streamline and build capacity within communities has been recognised by governments[81].

Lack of shared vision: Placed-based approaches should be collaborative, bringing together important stakeholders, partners and community members to achieve a collective vision for the future[82]. However, stakeholders often have different understanding or views of terms such as 'place-based' and 'community-led', which results in miscommunication, limited coordination and misaligned expectations[83]. Building collaboration around a shared vision between initiatives and stakeholders will address issues of fragmentation, siloing, duplication and lack of coordination in current systems[82]. Establishing a public and accountable shared vision within a community will build community trust[84].

Challenges in monitoring and evaluation: Evaluation is challenging in place-based initiatives due to resource and time constraints and is sometimes not considered a central component of place-based programs[85]. The expected outcomes of place-based programs are often realised only in the medium to long-term, but short-term funding arrangements require evaluations that are immediate and short-term[84,85] limiting the effectiveness of place-based evaluations. Additionally, collaborating organisations in place-based initiatives can have different and conflicting evaluation requirements, methods and measures[85].

THE EVIDENCE

A common framework for collaborative or collective policy initiatives facilitates information sharing, outcomes evaluation of short, medium and long-term impacts of initiatives and clarifies roles of different levels of government and government agencies[86,87]. Frameworks for collaboration in place-based initiatives have been identified as useful for communities, local governments and other stakeholders to make collaboration more effective[88]. The *National Framework for Protecting Australia's Children* 2021 - 2031, provides for Australian governments, Aboriginal and Torres Strait Islander leaders and the non-government sector to work together to help children, young people and families in need of support.



The Framework establishes governance arrangements, with action plans providing for implementation and delivery, sets out outcomes to be achieved and details measures to improve information sharing, data development and analysis[89].

Community development can facilitate coordination of initiatives within a community, potentially achieving longer-term outcomes such as stronger and more cohesive communities, evidenced by changes in social capital, civic engagement, social cohesion, community safety and improved health[62,90,91].

Coordination mechanisms are known to help facilitate sharing of information across organisations, agencies and tiers of government[84]. This can also help to mitigate inefficiencies caused by the lack of coordination across government levels[87]. The Victorian government *Framework for Place-based Approaches* suggests the need to have a leading organisation or convener to support a governing group, to coordinate between different agencies and organisations and to manage administrative and logistical tasks in place-based initiatives[92]. The Latrobe Valley Authority (LVA) in Victoria, is an example of a coordination mechanism. It is a government authority established in 2016 to support the Latrobe Valley region through a sustainable economic transition[93]. LVA has a mandate to work across different sectors of government when necessary and to collaborate with local partners to drive economic transition. LVA is funded by the Victorian Government and reports having created more than 4000 jobs in the region between 2016 and 2021[93]. LVA also funds community infrastructure and facilitates monitoring and evaluation to measure and promote their impact[94].

PRIORITY POLICY ACTION

Establish a national community development framework and dedicated fund to support systematic multi-sectoral community-based collaboration and coordination of local place-based initiatives.

The Australian Government should work with the states and territories to develop and implement a national community development framework and fund that enables a coordination mechanism for the wide array of different, sometimes overlapping, programs and initiatives within a local community or region.

A national framework would provide:

- an overarching structure to guide the development, implementation and evaluation of place-based programs to support local communities;
- support for local collaboration and community-led solutions;
- coordination of diverse external funding streams and services; and
- opportunities for improved efficiencies across local service providers and community organisation through shared infrastructure and governance arrangements.

A national framework could also include a community of practice and resource library focussed on community development and place-based approaches to facilitate information sharing across communities and help to address gaps in local knowledge and expertise.

The framework should be supported by a dedicated fund providing multi-year grants to local collaborations for the coordination and implementation of place-based health and wellbeing initiatives, particularly in communities with high levels of disadvantage.

POLICY OBJECTIVE 1

Enhanced community capability and capacity through systematic collaboration and place-based, community development

Long-term funding

Community organisations and service providers face significant challenges due to short-term funding contracts and a lack of financial security. National and state funding for community sector services, including through non-government organisations (NGOs) and local government authorities (e.g. Australian Government Department of Social Services (DSS) community grants, state-based programs), should provide for stability and security of service provision and workforce within communities through longer funding terms.

Community service providers, NGOs and other community-based organisations play an important role in supporting the wellbeing of communities across Australia. The sector helps to build community capacity and capability and delivers vital services to underserved and disadvantaged communities. These essential services are often commissioned or funded by governments and the sector is a significant contributor to the national economy. However, a market-based service commissioning model with short, restrictive funding terms undermines the sector's potential to be more effective, limiting their capability to contribute to their communities[57].

Funding to community service organisations should provide flexibility for programs and initiatives to be co-designed and implemented with community, focussing on addressing community needs and measuring outcomes. Longer-term funding allows community service organisations to build their expertise and capacity to deliver more efficient outcomes. It also recognises that outcomes in improved community capacity and capability will be apparent and measurable in the medium and longer term.

THE PROBLEM

Short-term funding of place-based approaches hinders evidence of long-term potential: Funding of place-based initiatives is often short-term, providing limited evidence of the longer-term potential of these approaches[93]. The reliance on 12-month or 2-year funding agreements creates uncertainty for service providers and their staff, leading to instability in planning and operations[95]. Short-term funding restricts the potential to evaluate potential outcomes through such initiatives.

Short-term funding leads to high staff turnover: Short-term funding for place-based initiatives and community services imposes limitations on recruiting and retaining staff. This challenges worker security, leading to staff turnover, which can undermine the ability to form long-term relationships with communities and across provider networks. Lack of funding can also mean expenditure on professional development and training is low[96].

Program-based funding leaves organisations with a shortfall for ongoing operational costs: Program-based funding often doesn't allow coverage of the full cost of service delivery including organisational, operational and essential function costs. Many contracts preclude the use of funds on essential infrastructure, management and administrative costs[96]. Indirect costs incurred by not-for-profit organisations can be two to three times higher than the amount covered by the relevant funding agreements[97].

Short-term funding arrangements are inadequate for comprehensive community co-design: Appropriate community consultation, co-design and collaboration take time and short-term funding cycles do not allow time for these to be undertaken in a genuine and meaningful way[98,99].

Conditions imposed by grants are restrictive: Restrictive funding arrangements hinder organisational flexibility to respond to community needs[96]. This restriction can also impede shared local decision-making[57].

THE EVIDENCE

Many reviews have highlighted that flexible and sustainable long-term funding is crucial for successful place-based approaches[86,100,101]. Funding over a longer period of years can provide confidence to communities, offer security to organisations and their employees and allow for adaptation to new ways of working and relationship building[101]. Long-term funding has been a key enabler in the implementation of Stronger Places, Stronger People (SPSP) – a community-led, collective impact initiative, working in ten communities across Australia to address disadvantage and create better futures for children and their families. The initiative is supported by the Australian Government in partnership with state and territory governments with the shared commitment by all parties to a local strategy in each community. The Australian Government has provided total funding of $99 million to partnerships under this initiative with additional significant investment from state and territory governments and philanthropic organisations[102].

In June 2024, the Queensland Government announced an intention to introduce default minimum five-year funding terms for service arrangements for community services organisations, with exceptions where justified by specific policy or service delivery grounds. Additionally, the government announced standards including that six months notice is to be required for cessation or non-renewal of contracts and that contract renewals are to be confirmed within three months of the contract end date[103].

The Department of Social Services (DSS) national consultation. *A stronger, more diverse and independent community sector*, acknowledged that funding terms of two years or less often provide less certainty in the community sector. The DSS report on the consultation said the solutions included simplified grant processes, funding providing for the full cost of service delivery and longer-term, flexible grants focussed on outcomes. Funding should enable community service organisations to undertake proper consultation and co-design, allow for changes in demand and community needs and support place-based approaches[57].

PRIORITY POLICY ACTION

Establish default minimum five-year funding terms for community organisations and service providers.

Funding should be prioritised to organisations already embedded in communities and funding guidelines should provide flexibility in the use of funds, including for ongoing operational costs.

POLICY OBJECTIVE 1

Enhanced community capability and capacity through systematic collaboration and place-based, community development

Community development workforce and volunteers

Community development is a holistic approach to improving the health and wellbeing of communities that emphasises the central role of local expertise and knowledge in developing community-led solutions to complex issues. Community development approaches also involve the redistribution of power to local communities, prioritise building community capacity and capability and tend to have long-term outcomes. Enabling self-determination and empowering community members to challenge inequitable conditions is considered particularly relevant for disadvantaged communities[4].

Effective community development requires a skilled workforce with good relationships to and with the community in which they work. Support for a dedicated and skilled community development workforce is required to provide professional expertise and leadership to build capacity and capability in disadvantaged communities and to resource place-based community development initiatives.

While the community sector should be properly supported to have a robust paid workforce and not be overly reliant on volunteers, the value and contribution of volunteers should be recognised. Volunteers in communities are often the backbone of community cohesion and support. The volunteer workforce and volunteer-involving organisations (VIOs) should be supported to engage in community development and community-benefiting work. Systematic and ongoing support should include insurance, training, cost reimbursement and professional support networks.

A national funding framework for community development workforce roles and for volunteer engagement and support to build the capacity of communities to engage in place-based initiatives should be established.

PROBLEM

A previously robust community development workforce has dwindled over time: Community development was professionalised in Australia during the 1970s and '80s and became part of the social and community services industry alongside professions such as social work. In the 1990s, with the shift to free market economics and privatisation of many community programs, the community development workforce dwindled and the focus of community development work shifted to community support roles in the private sector[104]. A focus on efficiency and competition as well as contract-based work meant a loss of focus on locality and participation and with it a loss of funding for community development[105,106].

Workforce development is restricted by program-specific and time-limited funding: Public policy responses to community issues and needs are usually provided through discrete and separate program funding arrangements. The 'problem' is often defined by government agencies, 'outcomes' are pre-specified and there are defined timelines[4]. Programs often target individual behaviours, disregarding the community and individual context[19]. Short-term funding and a lack of clarity around renewals, make it difficult to attract and retain a skilled workforce[96]. Funding tied to programs is also restrictive in how it can be allocated. This can mean workforce activities are limited to program delivery requirements and not available for broader collaboration or community development. Training and professional development opportunities are often out of scope[96].

Volunteering rates are declining: While many (~83%) VIOs need more volunteers, the rate of formal volunteering in Australia has been declining since 2010[107]. The COVID-19 pandemic contributed to a sharp drop in volunteer numbers exacerbating the existing trend of lower volunteer engagement arising from an ageing population, rising inequality, cost-of-living pressure, mental health challenges, unstable resourcing of volunteer programs and a lack of volunteer infrastructure[107,108].

VIOs lack sufficient resources: Limited resourcing leads to constrained capacity to attract, support and retain volunteers. Almost a quarter of VIOs do not offer insurance to their volunteers; administrative burden and a lack of technology investment reduce managers' time for relationship building with volunteers; and restrictive funding arrangements limit flexibility and agility of organisations[107].

Volunteering costs money: While volunteers give their time for free, they incur personal costs. In 2019 volunteers spent, on average, $1,710 on their volunteering with only $212.65 being reimbursed[108]. This left volunteers on average $1,497.11 out-of-pocket. The costs of volunteering for individuals are often prohibitive, particularly for those with fewer resources[108].

THE EVIDENCE

Community development education and training is provided in tertiary education institutions. The Australian Community Workers Association (ACWA) sets standards for and accredits education and training courses[109]. Jobs and Skills Australia data shows that more than 28,000 people were employed in community work in 2021 with 61% working full-time with a workforce median age of 45[110]. Most are employed within the community services sector by not-for-profit organisations or government agencies[109].

Community development workers support and resource communities to collaborate and build capacity. They build local networks, empower the community, undertake community engagement and plan, deliver and evaluate projects and programs. The role includes a focus on facilitation, education, capability building and resourcing[4,62].

In addition to a skilled community development workforce, volunteers involved in community development need to be adequately supported. The *National Strategy for Volunteering* (2023) by Volunteering Australia set out strategic objectives including supporting infrastructure and policies development for capacity and capability improvement of the volunteer workforce and sector. The strategy aims to build volunteering within communities and to help VIOs deliver more structured and supported volunteer experiences. The strategy also promotes a community-led approach to volunteering[107].

Improving the flexibility of models for volunteer involvement, including autonomy and virtual volunteering, can enhance volunteer recruitment and retention[111,112]. Improving policies, supporting infrastructure and technology access would help to reduce the administrative burden on VIOs[107].

Reimbursement of associated costs for volunteers would facilitate volunteer participation and retention. Reimbursement of out-of-pocket costs for volunteers is recommended in the *National Standards for Volunteer Involvement* (2024), but VIOs often do not have the resources to do so[108,113].

PRIORITY POLICY ACTIONS

1. **Invest in and regenerate the community development workforce, including specialised community development worker roles, nationally.**

   Communities should be supported to establish and maintain a community development workforce to build community capacity and facilitate coordination of responses to community needs and priorities.

   The community development workforce should be supported with skills, leadership and career development activities, and long-term planning for workforce continuity.

2. **Invest in ongoing provisions for community organisations to recruit, retain and support volunteers to contribute to community initiatives and capacity building activities.**

   Community sector organisations should have systematic and ongoing support for the volunteer workforce. This should include funding capacity to provide for insurance, training, cost reimbursement and professional support networks.

POLICY OBJECTIVE 2

Healthier environments through the appropriate use of planning, regulation and legislation

Local government health and wellbeing plans

The crucial role of local government in the health and wellbeing of local communities should be recognised nationally and supported by both federal and state/territory funding. States and territories should work together, potentially through the National Cabinet, to implement consistent requirements for local government health and wellbeing plans. The Australian Government Financial Assistance Grants program could be increased to provide national leadership and support for local governments to develop and implement these plans effectively[116].

Local government health and wellbeing planning should be informed by enhanced data collection related to community needs and local health and wellbeing priorities[117].

THE PROBLEM

Local governments are limited by the state and territory legislation governing their roles and responsibilities: Health and wellbeing plans and responsibilities are not mandated for all local governments nationally. For example, New South Wales (NSW) does not require local governments to have a role in health and wellbeing, whereas Victoria does through the *Public Health and Wellbeing Act* 2008, which aims to protect public health and to prevent illness, injury and disease, disability and premature death among Victorians[118]. The Act gives both the state and local governments specific responsibilities for protecting and improving health and wellbeing. State-wide public health and wellbeing plans are developed to guide implementation of these responsibilities and local governments are required to develop health and wellbeing plans. The most recent state-wide plan sets out 10 priority action areas for state agencies and for local governments[119]. In contrast, the absence of a legislative framework for the roles and responsibilities for local governments in public health and wellbeing has been shown to lead to limited and inconsistent action for communities in NSW[120].

Financial and resource constraints hinder local governments' ability to address health and wellbeing: In those jurisdictions that have required local governments to have wider health and wellbeing responsibilities for their communities, additional or dedicated resources to support this is limited, particularly in disadvantaged communities. Local governments have reported that limited funding and the absence of support from higher levels of government hinder their efforts to support and improve health and wellbeing in their communities[121].

THE EVIDENCE

Several state governments have established provisions for local governments to explicitly consider and support the health and wellbeing of their communities. South Australia and Victoria require local governments to develop municipal health and wellbeing plans, with Western Australia to do so by 2026[114]. Similar requirements are absent in other states[115].

In some countries internationally, local governments play a significant role in public health. In the United Kingdom, the *Health and Social Care Act* 2012 tasks local governments with promoting public health through the development of *Joint Strategic Needs Assessments* and *Health and Wellbeing Strategies*[122]. Similarly, Toronto's *Public Health Strategic Plan* 2024-2028 emphasises the important role of local governments in promoting community health through evidence-based public health strategies[123].

The disparity between health and wellbeing initiatives by local governments in Victoria, which are required to address public health and wellbeing in their communities, and those in NSW where there is no similar provision, is considerable. In Victoria, almost two-thirds of local governments (63.3%) engaged in sustainable water management in food production compared to 29.7% in NSW; and almost all Victorian local governments (91.1%) support nutrition in vulnerable populations compared to 62.5% in NSW. In NSW, only 3.9% of local governments have encouraged food retailers to offer healthy, sustainable food options, compared to 31.6% in Victoria[124].

PRIORITY POLICY ACTION

Require and resource the development of Municipal Health and Wellbeing Plans in all state and territory jurisdictions.

State and territory governments should work together, potentially through National Cabinet, to establish consistent requirements for the development and implementation of health and wellbeing plans by local governments nationally. Requirements should include public reporting by local governments on health and wellbeing outcomes and progress against the objectives identified in the plans, with data collection facilitated through organisations such as the Australian Institute of Health and Welfare (AIHW).

The Australian Government's funding programs should adequately support local governments to develop and implement health and wellbeing plans.

POLICY OBJECTIVE 2

Healthier environments through the appropriate use of planning, regulation and legislation

Health and wellbeing planning overlays

State and territory governments play an essential role in the health and wellbeing of Australians and are responsible for implementing various preventive health policy initiatives, including:

- **breast cancer and other cancer screening programs;**
- **immunisation programs through schools; and**
- **tobacco and e-cigarette restriction measures (e.g. smoke-free legislation and regulations) within various settings**[125].

All states and territories have public health legislation designed to protect, promote and enhance the health and wellbeing of their residents. State and territory governments also have planning responsibilities for cities and communities. The planning provisions provide for decisions about land and housing developments as well as development of infrastructure, public housing, transport, water and sewerage, and public and recreational services, all of which can influence the health and wellbeing of communities[63]. Urban planning, primarily governed by state legislation, delegates significant planning responsibilities to local governments, such as approving housing, land, commercial and retail development applications[126]. A lack of health and wellbeing considerations in planning legislation in the states and territories limits the capacity of local governments to make decisions under that legislation with consideration of the health and wellbeing impacts of planning proposals and applications.

A health and wellbeing overlay in the planning legislation for all jurisdictions would enable local governments to prioritise the health and wellbeing of their constituents when considering planning and development applications. This would include requirements to appropriately consider health and wellbeing impacts related to urban design, food environments, housing development and local environmental impacts[127].

THE PROBLEM

Planning legislation in states and territories does not consider health and wellbeing impacts: Planning legislation in all state and territory jurisdictions provides the framework within which local governments make planning determinations within their communities. Many commercial and infrastructure developments that require consideration under planning legislation can influence the health and wellbeing of communities. Despite this, the absence of mandatory consideration of health and wellbeing impacts in planning determinations exposes disadvantaged communities to less healthy environments than in other communities, by limiting the capacity of local governments to consider the health needs, circumstances and priorities within their communities.

Civil/administrative tribunals can overturn planning rejections that are based on health and wellbeing influences: Local governments encounter challenges when attempting to address the commercial determinants of health in their planning decisions. Efforts by local governments to limit the density or location of potentially harmful products such as fast-food outlets, alcohol retailers and tobacco shops are often overturned by state and territory civil/administrative tribunals[128].

For example, planning provisions in the state of Victoria, such as the *Planning and Environment Act*, 1987[129] and the *Planning and Environment Regulations 2015*[130], limit the capacity of local government to regulate the location and density of fast food outlets. While local government can approve or reject applications, decisions can be appealed to the state's civil and administrative tribunal by applicants or objectors, with appeals determined on a merits basis in accordance with the planning legislation and regulations. Further appeals are restricted to points of law[131]. Across Australia, 77% of judicial decisions favour industry interests, often dismissing health-based evidence presented by local councils defending public health measures under their Municipal Public Health and Wellbeing Plans[127,132].

Disadvantaged areas have a higher proportion of 'unhealthy' venues: People living in the most disadvantaged local government areas are disproportionately exposed to fast food outlets, with 51.9% of residents having one within

1,500 meters of their homes, compared to 40.7% in the least disadvantaged areas[133]. This disparity exacerbates health inequalities in these communities[132].

THE EVIDENCE

Whilst the *Victorian Public Health and Wellbeing Act* 2008 requires local governments to create health plans, enabling them to address issues like food access and community infrastructure, the state's planning laws do not support this responsibility[119]. More broadly, in jurisdictions in which local governments do not have a mandated role in the health and wellbeing of their communities, such as NSW, the lack of a health and wellbeing overlay for planning legislation and implementation gives local governments little scope to do so[120].

In Toronto, Canada and the United Kingdom, strategic plans and legislation provide for consideration of health priorities in urban planning and policy. In the *Toronto Public Health Strategic Plan*, major planning decisions by local governments must consider public health impact assessments. This effectively integrates health and environmental considerations into local planning to address issues like food access, housing, and air quality[123]. *The Health and Social Care Act* 2012 in the United Kingdom mandates local governments to develop health and wellbeing strategies. Health and Wellbeing Boards are statutory committees in all upper-tier local authorities, those councils with responsibility for provision of the largest and most expensive local services (i.e. education, social services, libraries, main roads, public transport, fire services, waste disposal and strategic planning) for a cluster of local councils. The upper-tier local authorities Health and Wellbeing Boards align public health objectives with planning, encouraging healthier environments through urban design and policies supporting physical activity and access to healthy food[134].

In Australia, overlays have been implemented to address public and social issues of significant concern. In South Australia (SA), a bushfire management overlay sets out provisions to guide the development of land and ensure bushfire risk is considered before new developments proceed. By mandating that building applications address bushfire risks, ensuring safety measures are enforced, SA's bushfire management overlay offers a model of integrating risk management into planning processes[135].

In NSW, a *Premier's Priority Childhood Overweight and Obesity Delivery Plan*, established in 2016, has provided a multifaceted whole-of-government overlay to reduce overweight and obesity rates in children by 5% over 10 years. The plan provides for coordinated policies and initiatives in all relevant areas of government policy and service[136].

The *National Tobacco Strategy* 2023-2030 and staged e-cigarette reforms implemented in 2024 support local governments to promote smoke-free environments through initiatives identified in their municipal public health and wellbeing plans, local laws, and enforcement of the Tobacco Act 1987. Local governments are supported by programs like the Local Government Tobacco Education and Enforcement Program, to undertake education and enforcement activities to reduce tobacco and e-cigarette use[137]. In 2022-23, Victorian councils conducted over 11,000 inspections of premises to ensure compliance with tobacco and vaping regulations, demonstrating the vital link between local government action and public health outcomes[138].

PRIORITY POLICY ACTION

Implement consistent health and wellbeing overlays in all state and territory planning schemes.

State and territory planning frameworks and legislation should require the consideration of health and wellbeing impacts in all planning determinations. Local governments should be supported to access and apply health data relevant to their communities to enable evidence-based planning decisions that support community health and well-being.

POLICY OBJECTIVE 3
Investment in tailored preventive health initiatives for disadvantaged communities

Health literacy and prevention

Health literacy is the capacity for people to access, understand and use health information in ways that benefit their health[11]. Health literacy is determined both by the skills and abilities of individuals as well as the demands and complexity of the environments in which people live[32]. It is closely linked to social determinants of health, such as socioeconomic status and education levels[139,140].

Low health literacy is a significant factor contributing to poor health outcomes, particularly in disadvantaged populations. Evidence highlights the importance of developing tailored, culturally appropriate programs that are co-designed with communities. *The National Health Literacy Strategy (NHLS)*, currently in development, should be implemented, with priority attention to disadvantaged communities. Concise, valid and reliable health literacy indicators and metrics should be developed and utilised in periodic population surveys and as a practical screening instrument for tailored interventions. The health literacy of health professionals should be addressed by establishing and implementing health literacy competencies in professional education, continuing professional development and workforce accreditation standards.

THE PROBLEM

Low health literacy is associated with a range of poor health outcomes: Low health literacy affects an individual's capacity to engage in health-promoting behaviours, to follow self-care information and advice and to use healthcare services. Low health literacy can be a significant barrier to primary healthcare. Communities and people with low health literacy tend to have higher rates of emergency department visits, hospital admissions and ambulance use. They also incur higher healthcare costs with poorer health outcomes[141–144]. Low health literacy contributes an additional 3–5% to total healthcare costs[145,146].

Health literacy is widely understood in narrow terms: Health literacy extends beyond individual skills and includes the wider environmental and social factors that affect how an individual engages with their own health and healthcare[11]. Despite this, health literacy is commonly thought of as functional literacy, that is, the capacity of an individual to understand and use health information. The Australian Commission on Safety and Quality in Health Care (ACSQHC) in 2012 found that most health literacy initiatives in Australia focused on building functional literacy, while only a small percentage of health literacy initiatives addressed broader aspects such as health literacy environments, workforce training, and knowledge sharing[68].

Differing views of health in culturally diverse communities: Health, healthcare, disease and its management are perceived and experienced differently across different cultures[147]. The holistic concept of health and wellbeing for First Nations peoples encompasses the physical, social, emotional, cultural and spiritual wellbeing of both individuals and communities[148,149], which are important to consider in relation to health literacy. First Nations peoples may also navigate health through both Western and Aboriginal frameworks, influencing their health attitudes, behaviours and decision-making[150]. Similarly, culturally and linguistically diverse communities such as Asian, Pacific Islander and other communities have specific understandings of health and healthcare, which can create barriers to accessing healthcare[147,151].

THE EVIDENCE

Health literacy, both in functional literacy and the broader dimensions of health literacy, affects the quality and safety of healthcare for individuals as well as their engagement in treatment and disease management decisions[68].

The broader dimensions of health literacy are measured through nine domains that encompass access to and capacity to use health information and to navigate the healthcare system. These are used in the Health Literacy Questionnaire of the *2018 National Health Survey*[152].

The NPHS emphasised the importance of an effective health literacy environment that offers person-centred, accessible and culturally appropriate health information with consumers as active partners in health literacy improvement. A priority initiative of the NPHS is development and implementation of a *National Health Literacy Strategy (NHLS)* to improve health literacy environments as well as individual self-care capabilities[32]. Australians should have access to trustworthy, culturally appropriate and easily understood health information and have the skills to find and use reliable health information across the media they prefer[153].

Healthcare professionals, particularly in general practice, have a direct role in helping patients to develop health knowledge to navigate their healthcare efficiently[154,155]. Integrating health literacy and culturally responsive training into professional education can contribute to improved patient outcomes[156].

Strategic investments in improving health literacy in communities with low health literacy would address poorer health outcomes and higher rates of healthcare use[144]. These could include investing in strengthening the health workforce distribution in regional, rural and remote areas[157], building workforce capability and competency to address community health literacy needs[158] and modifying funding mechanisms to promote awareness and action on health literacy[68].

Co-design approaches involving community members, health professionals and other stakeholders, have been promising in improving health literacy efforts[159,160]. During the COVID-19 pandemic, First Nations leaders in the Northern Territory collaborated with clinicians and communication experts to co-design 22 vaccine videos in 11 languages. This initiative addressed misinformation about COVID-19 vaccines by using trusted local leaders to deliver accurate information, empowering individuals to make informed choices. The co-design method helped prioritise relationships and local languages and built strong relationships and trust between First Nations communities and local health services[161].

PRIORITY POLICY ACTIONS

Investment in improved health literacy nationally should be prioritised and delivered through a long-term investment strategy.

A 10-year community health literacy development grants program, providing needs-based funding to disadvantaged communities for co-designed initiatives, should be established as a core implementation component of the proposed National Health Literacy Strategy.

Health literacy competencies for health professionals should be established and incorporated in professional education, continuing professional development and workforce accreditation standards.

Concise, valid and reliable health literacy indicators and metrics should be developed and incorporated in periodic national health surveys.

POLICY OBJECTIVE 3

Investment in tailored preventive health initiatives for disadvantaged communities

PHN and LHN collaboration

Primary Health Networks (PHNs) are independent organisations funded and accountable to the Australian Government Department of Health and Aged Care for the coordination of primary healthcare in their catchment areas[16]. Local Hospital Networks (LHNs) are established and funded by state and territory governments to provide public hospital and healthcare services to their communities[13].

PHNs and LHNs have shared population catchment areas and communities. There should be national coordination and accountability measures to ensure there is effective and nationally consistent collaboration on preventive health occurring between PHNs and LHNs.

PHNs and LHNs should be required by Australian, state and territory government policies to establish formal area health and wellbeing collaborations. They should be required to align, coordinate and monitor the need for and access to preventive health and health promotion interventions within communities in their shared catchment areas that have high rates of risk factors for preventable health conditions.

THE PROBLEM

Multiple and complex responsibilities for funding and services: Australia's complex, layered health services arrangements can pose problems with policy and service coordination and navigation for communities, organisations and individuals. The Australian Government has responsibility for primary healthcare and for a range of health protection and population health strategies and initiatives. State and territory governments have separate responsibilities for public hospital and healthcare services and for health protection and population health initiatives. Successive national reviews have consistently identified the multiple forms of system stewardship, system financing, service design and quality and safety considerations as major contributors to Australia's complex and often inefficient health system. All reviews have emphasised the need for structural reforms to streamline and provide cost-effective, coordinated health policies and services. Reviews have called for simplified governance and accountability arrangements; for new models of healthcare and best practice prevention, diagnosis and management/treatment with strengthening of primary care; for improved use of information, amongst other system improvements[162].

Variable and limited PHN and LHN collaboration for shared catchments: PHNs and LHNs are required to work together by the National Health Reform Agreement (NHRA) 2020-2025. A core function of PHNs is to "coordinate and integrate local health care services in collaboration with Local Hospital Networks (LHNs) to improve quality of care, people's experience and efficient use of resources"[163]. LHNs are similarly required "to work with Primary Health Networks to integrate services and improve the health of local communities"[164(p69)]. However, existing PHN-LHN relationships are variable[165] and the policies and guidance for managing the PHN-LHN relationship are inadequate[166].

LHNs do not have accountability for implementing Joint Regional Plans (JRPs): While joint regional plans are required to be developed with the involvement of both PHNs and LHNs, only PHNs have accountability for implementing plans[166].

THE EVIDENCE

Guidelines for PHNs and LHNs to implement joint regional mental health and suicide prevention plans have been developed. The guidelines encourage collaboration between PHNs and LHNs to coordinate data sharing and joint needs assessments to identify services, reduce duplication, and enhance efficiency[167]. Collaborative action by PHNs and LHNs can foster accountability and reduce fragmentation in the system.

NSW Health has established a state-wide, Collaborative Commissioning program to facilitate collaboration between PHNs and LHNs (known as Local Health Districts in NSW). Collaborative Commissioning promotes partnerships between NSW LHNs and PHNS with other service providers, with the aims of delivering value-based care, addressing community needs and reducing hospital presentations[168].

NSW Health is also leading the Lumos Program, a large-scale, collaborative data linkage project with PHNs and acute care providers (including LHNs) and other health services. The project includes connecting consumer data across various health services to map patient journeys for quality improvement in healthcare. LUMOS utilises data modelling to support primary care providers in adapting and tailoring services based on community and consumer needs. These programs and other similar state-based collaborative initiatives have potential to be implemented nationally[168,169].

The Productivity Commission Inquiry Report on Mental Health recommended that governments should "strengthen cooperation between PHN and LHNs by requiring comprehensive joint regional planning and formalised consumer and carer involvement"[165(p82)]. The PHN cooperative in their response to the report agreed the structure and incentives for PHNs and LHNs should be improved to foster genuine cooperation[166].

The NHRA includes an objective for national, state and territory governments to "work in partnership to implement arrangements for a nationally unified and locally controlled health system which will improve local accountability and responsiveness to the needs of communities through continued operation and collaboration between Local Hospital Networks and Primary Health Networks"[164(p7)].

PRIORITY POLICY ACTION

Strengthen systematic collaboration between PHNs and LHNs to design, implement and report on preventive health interventions tailored for individual communities.

This could be achieved by incorporating formal requirements for collaboration into the *National Health Reform Agreement*. PHNs and LHNs could be required to form formal area health and wellbeing collaborations with each other to align, coordinate, support and monitor preventive health initiatives and outcomes in their shared catchment areas. These collaborations should be accountable to national, state and territory governments for preventive health outcomes in alignment with the National Preventive Health Strategy 2021-2030 and relevant state and territory health and wellbeing strategies.

Health funding and models of care

Healthcare funding should be needs-based and support improved access to primary and specialist care in disadvantaged communities, particularly in regional, rural and remote areas. Funding should be delivered through blended, flexible funding arrangements that incentivise collaborative, coordinated and comprehensive models of care across the health system.

Although some blended payments have been introduced, current health funding in Australia is still largely based on fee-for-service, which does not adequately support preventive care or long-term multidisciplinary management of complex chronic conditions[162,170]. Blended funding models can provide efficient, flexible support for primary care services in delivering high quality multidisciplinary care, including preventive health care, to a wide range of patients with diverse and often complex needs[170].

Enhanced, flexible funding arrangements would support equitable access to comprehensive, coordinated, multidisciplinary team-based care that is inclusive of a wide range of different health professionals working to the top of their scopes of practice.

THE PROBLEM

Current funding incentives for general practice are not fit-for-purpose: Recent analysis, commissioned by the Australian Government and undertaken by KPMG, observed that the current incentives payments for general practice do not align with broader policy, have limited influence on accessibility and that their uptake is restricted in poorly resourced practices (which are often located in rural, remote or disadvantaged areas)[171].

Current funding arrangements do not adequately support best practice multidisciplinary models of care and impede health professionals working to their full scope of practice: Funding arrangements need to incentivise the provision of high quality care delivered by multidisciplinary teams of health professionals, which includes consumers as active participants in their own care. The current dominance of fee-for-service and largely single-episode healthcare provided under the MBS fails to incentivise best practice models of team-based multidisciplinary care for managing and/or preventing complex chronic conditions[162,172]. Existing funding models also restrict some professions from working to their full scope of practice and inhibit the provision of multidisciplinary team-based care in primary care settings[173].

The need for coordinated, integrated care has never been greater: As the proportion of people in Australia living with two or more chronic diseases continues to increase, so too does the need for coordinated care from multiple providers, across multiple systems, including health, aged care, disability and social services. However, current funding models do not adequately enable or support high quality, coordinated, integrated person-centred care[174].

THE EVIDENCE

A 2024 review, undertaken by Centre for Primary Health Care and Equity at the University of New South Wales, considered the available evidence regarding how different funding/payment mechanisms affect healthcare access, quality of care and multidisciplinary team-based arrangements. The review found sufficient evidence that blended funding models, which feature a mixture of fee-for-service, capitated and outcomes-based payments improve the quality of care and support multidisciplinary team-based care[170]. However, the review also found that while blended payment models show promise, there was a lack of evidence related to the impact of the different funding/payment models on health outcomes.

It has also been established in multiple studies that blended models would remove many perverse incentives that exist within predominately fee-for-service payment systems[175] and facilitate multidisciplinary, coordinated models of care[176].

There is strong evidence demonstrating that better coordinated care contributes to better health outcomes[170], and that care fragmentation and access barriers are most acute in regional, rural and remote areas with high levels of socioeconomic disadvantage[80,172,177].

Access to healthcare depends on the equitable distribution of health professionals across the country[178]. There are fewer health professionals in rural and remote Australia

than elsewhere, limiting access to care in these areas[177]. A range of Australian Government programs and funding incentives which aim to address access inequities and enhance primary care capacity have been or are soon to be implemented. These include initiatives aimed at reducing health workforce shortages, supporting innovative models of care and various financial incentives to improve quality of and access to care[170,179,180,183].

The Innovative Models of Care (IMOC) Program involves trialling various multidisciplinary models that can improve healthcare access and reduce chronic workforce shortages in a range of rural and remote locations. The IMOC Program aims to attract and retain health professionals to these locations by:

- enabling health professionals to work to their full scope of practice;
- implementing multidisciplinary team-based models of care;
- testing different employment models for health professionals; and
- supporting sharing of resources between small, connected communities[179].

MyMedicare, provides voluntary patient registration with a general practice with increased subsidy payments for telehealth consultations for registered patients[180].

The Practice Incentives Program (PIP) and *Workforce Incentive Program (WIP)* provide a suite of incentive payments that support quality of care and improved patient outcomes in general practices[170] and inducements for doctors, nurse practitioners and eligible allied health professionals to work in regional, rural and remote areas[181].

Initiatives focussed on improving quality of and access to care and the supply and distribution of the health workforce, include:

- a proposed *National Allied Health Workforce Strategy*[182], which aims to enhance access to allied healthcare across Australia for improved chronic disease prevention and management; and
- The *Working Better for Medicare Review*, which reviewed current health workforce policy objectives and distribution levers, has proposed significant reform to the existing arrangements to reduce access inequities[183].

These initiatives are evidence that there is pressing need to improve access to healthcare and reduce health inequities throughout Australia and that funding and workforce policy levers are vital to achieving this.

PRIORITY POLICY ACTIONS

1. **Establish long-term, needs-based health funding via flexible, blended funding models.**

   The design of blended funding models and funding incentives should be tailored to the local context and based on the best available evidence to:

   - incentivise coordinated, multidisciplinary team-based care;
   - support a suitable, sufficiently resourced health workforce in regional, rural and remote areas;
   - enable health professionals to work to their full scope of practice; and
   - improve healthcare access and outcomes, particularly in socioeconomically disadvantaged, regional, rural and remote communities.

2. **Support equitable access to comprehensive, collaborative care, which meets the needs of patients in disadvantaged, rural and remote communities through expanded eligibility for health professionals and services in multidisciplinary team care funding arrangements.**

   The composition of care teams should be flexible and tailored to the needs and available resources of their local communities.

Stigma and discrimination in health services

Stigma, discrimination and unconscious bias create significant barriers to equitable access in Australia's healthcare system, particularly for First Nations peoples and other priority population groups.

THE PROBLEM

Stigma, unconscious bias and discrimination restricts access to healthcare for many population groups: Data from the University of New South Wales *Stigma Indicators Monitoring Project*[184] shows that stigma and discrimination in healthcare are experienced by a wide range of population groups, including First Nations peoples, CALD groups, people with mental illness, people with disabilities, people with HIV, individuals who use drugs, LGBTQIA+ persons and sex workers[185,186,189]. All of these groups are more likely to also experience socioeconomic disadvantage. In 2021-22, 72% of surveyed intravenous drug users and 88% of surveyed sex workers reported stigma, discrimination or other negative experiences in healthcare services[185,186,189]. These population groups are less likely to seek or engage with healthcare services. A study by the University of Melbourne reported that gay and bisexual men in Australia who live in areas with higher levels of structural stigma were less likely to undergo testing or receive a diagnosis for HIV or an STI. They were also less likely to be aware of prevention strategies further exacerbating health inequities[189].

Systemic discrimination persists in Australia's health system: Systemic discrimination is a major driver of health disparities faced by First Nations peoples [190]. *The 2014–2015 National Aboriginal and Torres Strait Islander Social Survey* (NATSISS) showed that 33.5% of individuals aged 15 and older reported experiencing unfair treatment due to their ethnicity[191].

First Nations consumers also often perceive the healthcare system as disrespectful and disempowering, making them feel culturally unsafe. As a result, they may be less likely to follow treatment plans or may disengage from healthcare services altogether, leading to poorer health outcomes[192]. Culturally and linguistically diverse groups also encounter significant discrimination within the healthcare system, often resulting in inadequate access to services and culturally inappropriate care[193].

The impact of stigma extends to broader societal perceptions that influence healthcare access: For instance, Wigginton et al.[194] explored how policies to encourage tobacco cessation have stigmatised smokers, leading to their differential treatment within healthcare settings. This reflects a systemic issue where societal attitudes towards certain behaviours, health conditions, gender identities and older age, can lead to biased and discriminatory practices within healthcare systems[185,189,194,195], ultimately resulting in poor care engagement, lower treatment adherence and reduced use of health and community services[196,197].

Limited implementation of anti-stigma programs in medical and social care education: A review of past anti-stigma interventions for people with mental illness found that, while education-based programs show promise, their implementation in Australia seems to be limited[198]. The review highlighted that anti-stigma training exists in some pharmacy and nursing schools but remains limited. It also noted that many of the programs often overlook stigma faced by individuals with mental illness and their families, as well as by culturally and linguistically diverse communities, First Nations peoples, and LGBTIQA+ individuals[198].

Australia's expanding cultural diversity presents both opportunities and challenges for healthcare providers and service systems to develop and deliver culturally competent services[199]. Past efforts to promote cultural competence in healthcare have not been consistently coordinated and evaluated[200]. There has also been no comprehensive strategy for integrating cultural competence into health workforce training or ensuring that healthcare services are delivered in a culturally safe manner[200].

THE EVIDENCE

Research shows that anti-stigma training during professional education reduces unconscious bias and discriminatory practices and therefore reduces the potentially subsequent unequal treatment, particularly for disadvantaged groups[198,201]. By addressing biases early in medical education, healthcare professionals provide more compassionate, culturally competent care, improving patient engagement and health outcomes. Embedding anti-stigma education into medical and social care education aligns with broader health policies, such as the draft *National Stigma and Discrimination Reduction Strategy*, which emphasises the importance of reducing structural stigma in healthcare systems[202].

Supporting co-design in anti-stigma programs, such as engaging communities affected by stigma (e.g. culturally and linguistically diverse groups, First Nations peoples and individuals with mental health conditions), can be effective. By incorporating lived experience perspectives, programs can be tailored to specific challenges and ensure culturally appropriate solutions[202]. In line with the evidence, a draft National Stigma and Discrimination Strategy, developed by the National Mental Health Commission (NMHC), recommended that anti-stigma programs be led and co-designed by individuals with lived experience. These individuals should receive appropriate remuneration and training, enabling them to share their experiences effectively. The draft Strategy also recommended evaluation of the impact of co-designed programs[202].

PRIORITY POLICY ACTION

The proposed National Stigma and Discrimination Reduction Strategy should be implemented and adequately resourced to reduce stigma and discrimination and improve access across the healthcare system.

This should include:

- Upskilling of clinicians and other service providers by embedding stigma and discrimination reduction programs within core health professional curricula;
- Providing funding and system support for anti-stigma initiatives within the health and community service sectors, co-designed with priority population groups and
- Using non-stigmatised language and images in government media, campaigns and other communications."

Financial access barriers to health care

Despite a universal healthcare system in Australia, cost barriers limit access to healthcare for people who are socioeconomically disadvantaged, who live in regional, rural and remote areas and for those who have chronic conditions. Out-of-pocket expenses for individuals are high, leading to high rates of people forgoing healthcare.

Funding for primary and other non-acute healthcare, including MBS subsidies, should be weighted to provide for equitable population-based funding for disadvantaged communities.

Additional funding should be provided to primary healthcare services in communities with higher proportions of people receiving income support and Health Care Card holders. Funding for interpreters in communities with significant cultural diversity should also be available to support access equity.

THE PROBLEM

Socioeconomic disadvantage limits access to healthcare: People who are socioeconomically disadvantaged spend a substantial proportion of their incomes on healthcare and a significant proportion forgo healthcare because of cost[203]. They are less likely to use specialist care[69,204] and this is particularly apparent for children in early years[205,206]. Gap payments for GPs are also at an all-time high[72].

Rural and remote communities have reduced access to primary healthcare: People in regional, rural and remote areas lack access to comprehensive primary care. In remote and very remote Australia some people don't have any access to a GP and some have to travel more than 60 minutes to access primary care. The Northern Territory and Queensland have the highest proportions of people without access to general practitioner services[207]. Access to medical specialist services is much lower in medium sized and small rural towns than in large rural towns, regional centres and metropolitan areas[73,208].

Financial barriers limit access to allied health: Allied health is a significant component of health care of people with chronic conditions and for people with disability, older people and people with mental health issues. However, allied health services are less likely to be bulk-billed and commonly require an out-of-pocket payment by consumers. People experiencing disadvantage are less likely to use allied health care due to a lack of health insurance and limited capacity to pay out-of-pocket costs[208,209].

Financial barriers limit access to healthcare for people with chronic conditions: Chronic conditions lead to significantly higher out-of-pocket costs for individuals. People with chronic conditions are more likely to forego health care because of cost[210]. They are less likely to have private health insurance and also less likely to feel confident they can afford care[211].

THE EVIDENCE

To address the decline in bulk billing by GPs, a triple bulk billing incentive was announced in the 2023-24 Federal budget and introduced in November 2023. Under the scheme, the incentives are available to GPs who bulk bill concession card holders, pensioners and children. The incentives are scaled with larger incentives in more regional, rural and remote areas. In the first four months after introduction, the national rate of bulk billing increased by 2.1%. Some areas had a higher increase with 5.7% increase in Tasmania, a 4% rise in regional Queensland and an 8% rise in Bendigo in rural Victoria[212]. These incentives have demonstrated the benefit of weighted payments to provide increased access to healthcare for people experiencing disadvantage and in disadvantaged communities.

Brokerage funding is flexible funding for services to bridge the gap and barriers preventing people from accessing appropriate health or social care. Funding may provide for transport or meet the individual costs of seeing a healthcare professionals[213]. Brokerage funding has been used in a variety of specialised programs to support vulnerable individuals to have access to the health and social care they need. It has been shown to increase access to health and social care through personal or financial

support or both, for particular groups [214]. Flexible funding, through brokerage arrangements, to provide financial support for access to both primary and specialist healthcare for people in disadvantaged communities and priority population groups would give individuals access to healthcare they would otherwise forgo.

Some examples of brokerage funding arrangements in health and community services are:

- The Commonwealth Psychosocial Support Program (CPSP), provided by PHNs, has an option for brokerage funds for client needs that are not met through available services, such as for transport and access to some clinical supports[71].
- The Partners in Recovery (PiR), a former Australian Government program that supported people who experienced severe and persistent mental illness, had flexible funding to be used as brokerage funds for consumer needs when they could not be met through existing support services and channels. These funds could be used for medical assistance, short-term accommodation, transport costs and some household items[215].
- Specialist Homelessness Services, funded by the Queensland Government Department of Housing, Local Government, Planning and Public Works has brokerage funding that can be used for accommodation, utility bills, travel costs and specialist services including occasional childcare, mental health care, and counselling[60].
- Orange Door, a domestic and family violence support service that is part of Family Safer Victoria and funded by the Victorian Government Department of Families, Fairness and Housing (DFFH), has access to brokerage funds for immediate support and ongoing assessment and planning[216].

PRIORITY POLICY ACTION

Reduce financial access barriers to non-acute healthcare in rural and remote areas and disadvantaged communities through:

- **Further expansion of enhanced bulk billing incentives in rural, remote and disadvantaged communities; and**
- **Direct and targeted financial support (i.e. brokerage funding) for access to services for eligible individuals and families in disadvantaged communities.**

Enhanced bulk-billing incentives in rural, remote and disadvantaged communities would help to compensate for the lack of cross-subsidisation between fee paying and bulk billed patients.

Brokerage funding should include funding for access to nursing and other allied health services, in addition to or in replacement for, general practitioner services, and access to specialist care, transport, childcare, community legal services (e.g. to address elder abuse, housing and domestic violence needs) and respite care.

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