

## **Inquiry into COAG Reforms Relating to Health and Hospitals**

Submission from Royal District Nursing Service

31 Alma Road, St Kilda, Victoria

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The Australian Government is to be congratulated that it has taken on the challenge of introducing reform of Australia's health care system. There is a very clear need for such change if, in the long term, a high quality, integrated, sustainable health care system is to be available for future generations of Australians.

As Australia's largest provider of home-based nursing and health care, Royal District Nursing Service (RDNS) has watched with interest the reform process of the past couple of years. We have been encouraged by the increased recognition of the role that primary health care plays in maintaining the health and wellbeing of Australians. Continued issues, challenges and problems associated with the acute in-hospital system only serve to reinforce the important role and value of a robust community-based health system.

However we have been disappointed recently that despite the current language regarding a shift to focussing on out-of-hospital care as the long term solution for the health system, the majority of funds and new spending appears to continue to be allocated to existing programs. Indeed, even the name of the reform is flawed and rather than being about 'health and hospitals', it should be about 'health and *wellbeing*', i.e. preventing or reducing the need for hospitalisation in the future.

### **Increasing acute hospital capacity**

The Government has acknowledged in its recent 'A National Health and Hospitals Network for Australia's Future' that AIHW statistics show Australians enjoy a higher rate of hospitalisation than comparable OECD countries, so the announcement of funding for further hospital beds (1300 in the COAG negotiation) is a surprise and begs questions. Should this money instead be targeting the development of innovative ways to reduce the rate of, and need for, hospitalisation in the future through prevention and early intervention rather than increasing hospital capacity?

### **New targets for ED presentations**

Likewise, in the past decade much work has been undertaken in places like Victoria to reduce Emergency Department (ED) demand by avoiding presentations. The recent promise of a 4-hour treatment period in EDs has the potential to increase demand (and therefore delays) in EDs as it will encourage people who in recent years may have been discouraged to attend EDs because of lengthy waiting times and / or offered more suitable alternatives, to perhaps move back to a reliance on EDs for more minor ailments. This may be particularly so where attendance at a public hospital ED is a free service and alternatives may require a fee or co-payment.

The increase in hospital beds and the 4 hour maximum treatment time in EDs will certainly be popular with the general community. But we question whether the additional funding needed to support this will lead to a shift to non-hospital treatment necessary to underpin the future sustainability of the Australian health system. And of course the additional staff required to deliver on these promises are not currently available, so we wonder how this extra capacity will be resourced in the short to medium term.

### **Local Hospital Networks**

The introduction of Local Hospital Networks (LHNs) and Primary Health Care Organisations (PHCOs) is consistent with current structures in place in Victoria. Whilst it appears clear that current arrangements in Queensland and New South Wales, where funding and planning occur across very large geographic and population catchments, can be improved, the introduction of a sound governance framework will be necessary to underpin such change. Will this mean that current systems and processes which work effectively elsewhere, such as in Victoria will need to change?

### **Primary Health Care Organisations**

The purpose of PHCOs is still not clear and so it is difficult at this time for us to comment on what they should look like. Will their scope be as planning instrumentalities with some funding responsibility for innovation and new initiatives (the current model in Victoria for Primary Care Partnerships - PCPs), will they have full funding responsibility and oversight for their geographic/population base, or will they also take on a service delivery role? Such a diversity of scope and purpose is already seen in the Divisions of General Practice network, and it has been suggested that divisions will evolve into the new PHCOs. The concern with such a move is the current GP-centric nature of divisions. Will they be able to effectively and quickly move from their current strong GP focus to truly interdisciplinary organisations? We suggest that this is what is required to bring about system change.

Whilst it could be argued that the Primary Care Partnerships in Victoria already have this interdisciplinary framework including GP divisions as members, their function to date has been predominantly that of planner and manager of multi-organisation projects. Changes in governance arrangements would be required if their role were to extend beyond that. Resourcing the establishment of PHCOs will challenge - it is worth noting that the establishment of PCP partnerships in Victoria has taken 10 years to reach their current stage and the Victorian Department of Health has acknowledged that this has required significant resourcing in terms of funding by the department, significant human resourcing support from the department and a great deal of unfunded participation and good will by staff of the many agencies involved. The levels of resource required to achieve effective PHCOs should not be underestimated.

### **The overall focus of reform**

It has been said that this reform is the “biggest since the introduction of Medicare” and that this is a “once-in-a-generation opportunity” to bring about reform. The current situation following the

recent COAG meeting and Budget announcement has certainly opened the door for change but does not appear to have comprehensively grasped the opportunity for real reform of this magnitude. In the process of negotiation between the different jurisdictions we have seen substantial compromise and as a result there are many examples of funding 'more of the same' with "new" funding provided through existing funding streams. Existing funding programs of the Department of Health and Ageing, in particular the complex and restrictive funding program provided through Medicare appear likely to expand.

There have been suggestions that the MBS should be simplified. But instead it would appear that many new initiatives will be provided through Medicare therefore restricting access to these initiatives to those with provider numbers and not necessarily those who are best placed to provide the service. For example, funding has been allocated to GPs to employ further practice nurses to provide care outside of the GP clinic environment but across Australia there are nurses and other health professionals employed through other programs who already provide care in settings such as the home - RDNS and our interstate counterparts are examples. With new funding provided through Medicare there is a risk of duplication as GPs seek to set up systems and structures which duplicate those already in existence. Surely it would be more cost efficient to allow existing providers (even though they do not have a provider number) to be able to access this funding and provide this service. Not only is this likely to be more cost effective but it will likely be safer. Organisations such as RDNS have processes and protocols in place to ensure the safety of staff in the relatively uncontrolled environment of the patient's home. Will GPs be able to ensure the same level of safety protocols, and have the economies of scale to make this viable?

### **The impact of 'non-health' elements**

Evidence shows that meeting the health care needs of populations and communities cannot be done in isolation. In recent years the World Health Organisation has undertaken much work showing that the social determinants of health are vital if optimal health status is to be achieved. Yet here is a reform which doesn't address the impact of elements such as education, employment, housing, etc on the health status of the community. A more holistic approach which considers all elements of the individual and community is required, rather than focusing on the present (medical model) domain and the focus on mainstream health service.

In summary we submit that there are many positive elements to the current reform but sustainability can only be assured if funding is shifted from the in-patient setting to the full spectrum of the community setting with a focus on keeping individuals and the community well and less reliant on high-tech and expensive hospital treatment.