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Commentary

The future of community-centred health services in Australia: 'When too many beds are not enough'

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Abstract

The authors welcome a constructive debate on the future of community-centred health services. Therefore, we have written this piece in response to an article published by Cunningham in the previous edition of the *Australian Health Review* (Cunningham, *Australian Health Review* 2012; 36: 121–124), which was a very limited analysis and misleading critique of our previous contribution to this journal (Rosen *et al*. *Australian Health Review* 2010; 34: 106–115).

The focus here is necessarily brief and does not stand in for a detailed analysis of the evidence base. The aim instead, is to draw attention back to the broader political, economic and social dimensions of how the retreat from community health services has affected clinical care. We also outline a response to a longstanding assumption, or belief, that 'too many hospital beds are not enough' and may never be enough.

How we understand the problem of resource allocation in healthcare shapes the remedies that are considered realistic. We explain that the reasons for the systematic underdevelopment of community health services are complex, historical, and largely relate to political and economic factors, but they are still amenable to change.

What is known about the topic? There is a growing evidence base and consensus of expert opinion supporting the gradual shift in health service delivery away from hospital-based models of care to community-centred ones. Wherever possible, speciality community health services should be co-located with primary health care in communal shopping and transport hubs so that patients have access to 'one-stop-shops' providing both primary healthcare and community treatment, and support services. It is important that these speciality community health services retain their integrity and control of their budgets, but also that they maintain functional integration with their respective hospital-based services.

What does this paper add? In response to a recently published vigorous but narrowly targeted critique of community-based models of care, we explore the wider context of the debate about the appropriate balance between hospital and community health services. We pay particular attention to the current debate in mental health services.

What are the implications for practitioners? Clinicians need to understand the historical, political and economic factors that have influenced the underdevelopment of community-centred health services, so as to avoid unhelpful conflicts between specialists and those working in different care settings. Rear-guard attempts to restore the dominance of hospital-centric

services are unsustainable in terms of ethics and economic reality. Policy-makers and health planners should instead aim to rebalance resources in the health sector so that people in all age groups and regions have equitable access to the full range of human health and support services across the continuum of care.

Additional keywords: Australia, beds, community health, community mental health, community sites, future, emergency departments, hospital sites.

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A conundrum: when too many beds are not enough

The subtitle borrowed for this short article comes from Fine's[1] paper, which drew attention to the acute bed shortage facing the aged care sector in Australia during the mid-1980s. The 'wicked' planning problem[2] in the aged care sector at that time is similar to the one the broader healthcare sector faces today: how do we manage the trade-offs needed to rebalance hospital and community-based care?

Walter Leutz[3,4] describes the same dilemmas in his 'laws of integration'. He says 'your integration is my fragmentation', and this expresses the inevitable trade-offs facing planners and clinicians. He also highlights that 'all integration is local', which emphasises how important it is to achieve organisation on a human scale where trust can develop across service networks. It is all well and good to describe the challenges in planning health services and distributing funds, but doing something constructive about them is a much bigger challenge for proponents and critics.

The objective in the aged care sector in the 1980s was to shift some of the Commonwealth Government's considerable investments in residential aged care into the community by substituting packages of care provided in the home for additional nursing home beds. The same objectives were being pursued in the mental health sector through deinstitutionalisation. Reforms in the mental health sector were pursued by state and territory governments and reinforced through a series of national mental health plans and reports, all of which supported substituting community support for hospital beds and better integration of care.[5]

The recent feature article in this journal by Cunningham[6] challenged the analysis and conclusions drawn from the broad body of evidence about effective community mental health services[7] and community-based services.[8] It also critiqued the way this evidence has been used to support an argument for a stronger community-sector. In the following section, we outline an alternative analysis and viewpoint.

Towards a more helpful critique

More hospital beds, no matter how many are built, will be quickly filled unless alternative models of community-based care are strengthened. Some fear, however, that the expansion of community health services cannot be done quickly or effectively enough to divert demand for inpatient care. We disagree. Our argument for why investment in community-based services is needed to restore balance with inpatient services is outlined below.

In the area of mental health, the evidence favours community-based alternatives to many, though not all, hospital-based mental health services. One of the strengths of community-based mental health services is that patients can also benefit from the co-location of other services, such as primary health and counselling services, and support services provided by non-government organisations. The main objective of this 'one-stop-shop' model is to improve the integration of care and ensure patients are able to access services locally.

The roll out of the youth mental health service 'headspace' (www.headspace.org.au) is an example of this 'one-stop-shop' model of care.[9] Such integrated models of care,[10] together with extensive studies of community-based 24-h residential respite facilities,[11] early intervention teams for psychosis,[12,13] 24-h crisis services,[14,15] Assertive Community Treatment teams[16,17] and housing with mobile support initiatives (eg HASI)[18,19] have demonstrated the potential to reduce demand for acute-care beds. We accept, however, that these community-based services do not supplant the need for high quality acute hospital services, including emergency department (ED) services.[20,21]

The reasons why consumers may attend or are brought to EDs are complex. They are partly due to an increase in psychiatric emergencies associated with drug and alcohol ingestion.[22] However they are also partly due to the under-resourcing and shrinking of community mental health teams[23] especially in terms of their capacity to provide ongoing care management, crisis services after hours and mobile operations. Without a consistent roll-out of mobile community-centred services, which are actively responsive and mobile,[16,17] mental health, like other health sectors, has been reverting to a reliance on more passive–response services. These sedentary, hospital-based modes of community mental healthcare are more akin to traditional outpatient departments.[7]

We acknowledge that in an environment where there is competition for scarce health resources, some people will be concerned that the expansion of community health services will have a negative impact on EDs and acute hospitals. However we do not think that the habitual contest between clinical specialties or between hospitals and the community health sector is constructive, and this was never the intention of our original article.

Instead, in our original article we advocated for well informed and population-based planning in order to minimise the risk that effective demand management will be eclipsed by this paralysing contest.[7] We conclude that community health services should be co-located with emerging primary healthcare centres in community hubs. At the same time, they should also retain control of their speciality budgets, maintain their integrity as distinct subsystems of care and preserve functional integration with their respective hospital-based services.

We also contest the point made by Cunningham[6] that there is evidence that you can't close hospital beds. The evidence does

suggest that to close beds, better integration strategies are needed; it is not enough to simply substitute community health models of care for hospital-based ones. The Cochrane Collaboration's reviews of hospital in the home (HITH) services illustrate this point.[24–26] They show that HITH models of care are safe and appropriate for selected groups of patients. While the expansion of HITH services may mean that some hospital beds can be shifted into the community, not all of them can be because some inpatient services cannot be delivered at home.

In the mental health sector, there is a legislative basis for encouraging the expansion of community-based models of care. The principle built into state-based mental health legislation is that of the least restrictive alternative, so that hospitalisation will only occur if no alternative 'that is consistent with safe and effective care, is appropriate and reasonably available.' (NSW Mental Health Act 2007 (No.8) Chapter 3, Part 2, Section 35(5c). The same legislative rationale for shifting care into the community does not exist for most other community health services. Therefore, there is little reason to fear as yet that there will be a large-scale expansion into community-based care at the expense of the acute care sector.

What are the roles of legislation and politics?

To develop community health services in the future, primary healthcare services need to be strengthened, and political support for national legislation and alternative investment strategies needs to be secured. For this to happen, there will need to be changes in the popular understanding of what the health system is and does and a greater recognition of the implications of changing both demographic and morbidity profiles. A much greater focus on long-term investments and demand management in health will mean that planning will also have to be done differently. The health needs of the whole population will need to be considered, not just those who come into contact with hospitals.

In some states there is currently a legislative basis for restoring the balance between hospital and community-based models of care more broadly. In NSW for example, one of the purposes of the NSW Health Services Act of 1997 is to improve (i.e. to promote, protect and maintain) the health of the population. However, this population focus is unlikely to emerge while political attention focuses largely on the acute hospital sector, as it has done in the past. In 1995, for example, Premier Bob Carr made a courageous election promise to either halve hospital waiting lists, or resign. Bed-fetishism was also a feature of the recent national health reforms, epitomised by Kevin Rudd's Prime Ministerial hospital bedside photo opportunities in early 2010. It was also reflected in John Howard's pre-election decision in 2007 to buy back and rebuild the Mersey Hospital for the local community of Burnie in Tasmania, rather than allow it to be replaced by the contemporary polyclinic (complemented by an acute general hospital in a nearby town) as proposed.

In periods of resource scarcity, the pressures to fund acute care and emergency interventions and reduce waiting times come at a cost. It generally means that enhancements in these areas will take place at the expense of longer term strategies to reduce demand, and that more 'social' models of care and the primary and secondary preventive end of the care continuum will suffer from relative neglect (p. 4).[27]

Unblocking the ED and avoiding hospital admissions: where does community health fit?

Although some may argue that ED congestion can be blamed on the primary care sector's failure to reduce or divert demand, we think this is drawing a long bow. Demand for ED and acute hospital beds has complex, multifactorial causal pathways[23,28–30] and can be managed in several ways:

- Long-term preventative strategies to improve the general health of the community and minimise chronic diseases;
- Health promotion programs;
- Physical activity and falls prevention programs for the general aged population;
- Targeted programs for people identified as at-risk such, as those with mental health problems or chronic health conditions;
- More subacute and community respite beds to allow longer term patients from 'blocking up' acute beds;
- Alternative planned pathways to inpatient services instead of through the ED;
- Early discharge services with adequate postacute support and community nursing;
- Rehabilitation and secondary prevention services based in the community to improve people's function and reduce future demand.

Hospital demand management programs are one way of reducing demand for hospital care in the community-sector. Unfortunately, there is only limited research done in this field, and the studies that do exist vary widely. As a result, it is difficult to directly compare findings from many of the studies. Despite this, the Cochrane Collaboration has synthesised research on ED avoidance and early discharge programs.[24,25,31] It revealed that some studies found hospital avoidance and programs to be up to 50% less expensive than routine hospital care, while others found that the programs are more expensive than routine care. However, overall they found that hospital-at-home programs were generally effective in facilitating early discharge of acute patients, preventing avoidable readmissions and providing a safe alternative to routine hospital care.[8]

The health funding landscape is changing

Managing demand for hospital services is one strategy but there is a more important, overarching problem. Currently, we lack a mechanism for the rational allocation and distribution of health funding, one that is independent of historical activity levels. With the advent of the Independent Hospital Pricing Authority and implementation of activity-based funding (ABF) the large scale system incentives will be geared to increasing the acute care 'outputs' of hospitals.[32]

The shift to ABF is particularly problematic in the area of mental health. Diagnosis-related groups (a core feature of ABF) are not a suitable mechanism for classifying and funding episodes of mental healthcare as they do not easily accommodate models of care that integrate community support services.[32,33] Under ABF, it will also be harder to enhance the resources for community care, particularly specialised community mental healthcare, because

currently the Commonwealth will not fund additional health services unless they are designated as hospital-based.

The dominance of fee-for-service funding in general practice is also an obstacle that prevents the delivery of integrated community mental health services. Under this system, general practitioners (GPs) have few incentives to work collaboratively with other healthcare providers in the acute or community health sectors. Although the roll-out of Medicare Locals may have some benefits for patients who need integrated care in the community, Medicare Locals are unlikely to be able to make a significant difference in the face of the strong financial incentives that encourage many GPs to work in relative isolation.

There are some positive signs on the horizon. The Commonwealth Government, through its investment in the Partners in Recovery program and the National Disability Insurance Scheme, will fund coordination of care and personalised budget support packages. This initiative could be strengthened if there were also some funding incentives for the states to ensure that mental health workers provide evidence-based modules of clinical and functional care which are of proven effectiveness for the most disabled in the community (e.g. Assertive Community Treatment teams).[16,17]

The argument we have made here for better integrated healthcare services does have its foundation in evidence, but is also made in an effort to offset the limitations of the dominant funding models. To effectively manage complex mental illnesses, health services must do much more than just focus on the quality of acute care; patients also need to be able to access a range of high-quality health and support services in the community. The economic benefits of enhancing resources for the community sector have been previously demonstrated. Knapp *et al*. in the UK[34], and Access Economics in Australia[35] have shown that investment in community mental health services returns one of the highest benefits-to-cost ratios in the health sector.

Conclusion

In seeking to find the right balance between community and hospital models of care, it is vital that evidence and rational policy-making play a role. There is a growing consensus that the balance should be shifting firmly towards the community, while still integrating hospital and community care.[10,20] The World Psychiatric Association International Guidance[21] now proposes that most services should be provided in community settings, close to the populations they serve, and that hospital stays be reduced as far as possible.

While some have asserted that 'psychiatry does not need any beds', we do not agree with this. A prominent academic in the field, Mario Maj[36] has said that 'we have learnt from experience that public hospital beds are necessary in psychiatry'. However, we need to make sure that the justification for inpatient services is based on evidence and rational resource allocation decisions, not merely on past experience or consensus among the medical establishment. In wrestling with the decision about resource allocation in mental health it is worth keeping in mind that psychiatric inpatient care has never been shown in any rigorous studies to be superior to comprehensive community-based alternatives to inpatient care.

Far from being oversold, community mental healthcare is being squeezed by hospital-centric and fee-for-service funding arrangements. We are sympathetic to clinicians' concerns over the pressure on EDs and the reduction of general hospital beds based on invalid planning assumptions. However from a population planning perspective, it must be acknowledged that most of people with a mental illness will always be in the community, so support for them and their families must therefore be available where they live.

In 2008 the WHO celebrated 40 years since the Alma Ata Declaration with the reminder that the entry point to health care has to be in the community with strong connections to the rest of the system. The community sector is vital to the health system because it is the first level of contact for individuals, the family and community. It brings healthcare as close as possible to where people live and work, and therefore constitutes the first element of a continuing health care process.[37]

As for mental health, there are important lessons to be learnt from initiatives that aim to shift the balance between community and hospital psychiatry. These lessons show that there is always a push to reinstitutionalise people with mental illnesses when reformers try to deinstitutionalise them and help them reclaim their full citizenship in the community.[38] We need to not only redistribute some of our limited resources to the community, but prevent the regressive influence that a traditional institutional mentality or the clinical elite can exert. This can occur long after institutions have been downsized or even closed, causing a loss of momentum in the process of transforming the clinical culture.[38]

We must also get beyond the tendency to implement isolated pilots projects leaving a wasteland of poor and mediocre services in between. Instead, we need evidence-based interventions and service delivery systems to be rolled out on an equitable and sustainable basis. They should be promoted and protected by our new standing mental health commissions, operating at arm's length from services and government administrations.[39,40] These commissions need to be able to withstand changes of governments and political flavours. They need to be able to monitor the quality of services, advocate for reform and report to the highest level of governments, legislatures and the public. Most importantly, they need to earn and retain the trust of consumers, families, and the community.

Competing interests

The authors declare there are no competing interests.

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