



Australian Health Care Reform Alliance

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SUBMISSION FROM

THE AUSTRALIAN HEALTH CARE REFORM ALLIANCE

TO

***SENATE FINANCE AND PUBLIC ADMINISTRATION REFERENCES
COMMITTEE INQUIRY INTO COAG REFORMS RELATING TO
HEALTH AND HOSPITALS***

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Australian Health Care Reform Alliance

Contact details for June 2010

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Also before 3rd June and after 2nd July,
Chair: Tony McBride

1. Introduction

The Australian Health Care Reform Alliance (AHCRA) welcomes the opportunity to comment on the COAG health reforms. Alliance members see this current government process as a ‘once in a generation opportunity’ for significant reform, and urge all parties to seize it, not squander it. The National Health and Hospitals Reform Commission (NHHRC) report makes it abundantly clear that doing nothing, or doing little, is not a sensible option for addressing the looming problems in Australia’s health care systems.

AHCRA is a unique and broad alliance of national and statewide health organisations (representing health professionals, consumers and health services) that is seeking major change in the Australian health system to make it more equitable, accessible and sustainable. (See Appendix 1 for a current list of members.)

It has been very active since 2004 and now has a membership of over 40 organisations. It is unique in the health reform landscape in that it has deliberately set out to create a consensus among both the consumers of services and the professionals that provide them to create mutually beneficial and sustainable solutions to the key issues facing the Australian health care ‘system’.

2. Major issues that need reforming

The consensus among AHCRA’s diverse membership has consistently been that there are a range of very significant system-wide issues that need addressing urgently, the foremost of which are the following:

1. long-term improvement and sustainability not short-term gain
2. poor life expectancy of Indigenous peoples
3. unequal and inequitable access to, and outcomes from, health system
4. no one ‘health system’ in Australia, but multiple poorly coordinated systems which only the consumer really gets to experience
5. primary health care system particularly fragmented – need single more accessible and better coordinated system
6. need for a stronger focus on prevention
7. much stronger consumer participation throughout health system
8. significant workforce issues that need addressing
9. serious gaps in services in oral health (with enormous inequalities in access and outcomes) and mental health services needing urgent attention.

These are outlined further in Appendix 2.

2. Strong points in the reforms

COAG Agreement comprises some very positive initiatives

AHCRA congratulates the Federal Government for its resolve in both starting this major reform process (through the various commissions and taskforces in 2008 and 2009) and in progressing the process to this point, including negotiating with the States to reach the 2010 COAG Agreement.

The changes announced do go some of the way towards addressing some of the serious concerns raised by AHCRA members (consumers and professionals) and noted above about the way in which we currently plan and deliver health care. They do create the foundations and some of the building blocks for a shift towards a more efficient, better coordinated, more rationale and sustainable system.

Even though AHCRA has some concerns about its contents, including what is not included (see below), AHCRA does recognise that the Agreement and associated Federal Government announcements in 2010 do comprise some highly significant long-lasting reforms, and the Agreement can be considered a landmark in health policy in Australia. There is considerably more to do though.

The unprecedented extent of the investment in better health systems is also hugely important. Increased funding for both health care and for workforce development will have real impacts on the health and welfare of many people and on the sustainability of the system (especially the workforce initiatives). This too needs acknowledging although some of the commitments are misdirected.

Not all reform

Thus it has to be recognised that certainly not all of the Agreement and its associated funding will lead to long or even medium-term reform. A significant slice of funding has gone to ‘business as usual’ at the behest of (read ‘severe arm-twisting by’) the States and the final package is a result of political processes as much as serious health policy response. Even though the funding will provide welcome health care to people in the short-term, and hence is not to be ignored, a fair proportion of it will not contribute to longer term reform. This needs to shift the balance of spending towards the primary health and prevention sectors, aiming at permanently reducing the need for hospital care in the long term, not increasing it. AHCRA views the funding allocated to normal care to sweeten the deal with the States as a lost opportunity. It could have financed much needed oral health, mental health and Indigenous reform.

Shift of responsibility

AHCRA welcomes the shift in the centre of gravity of health system funding from the States towards the Commonwealth, through the Commonwealth assuming responsibility for the majority of hospital costs, all of primary health care and (nearly) all of aged care

funding. This will create serious incentives for the first time for the Commonwealth to provide effective primary and aged care services in order to minimise the (currently high) number of preventable hospital admissions on one hand and the unnecessarily long hospital stays experienced by older consumers.

This shift in responsibility, with associated national benchmarking and monitoring of standards and outcomes, also has the clear potential (if implemented sensibly) to both facilitate equitable funding of health care across the country, and to reduce some of the cost and blame shifting that characterise the existing system.

An even better arrangement would have been to establish an independent Health Commission (independent of government health departments), coupled with regional health bodies to address local needs but supported by State level health resources, would lead to a much more equitable system. ‘*Care follows funding*’ is a universal health systems rule, and one single funding authority could lead to simpler funding regimes where local professionals could offer optimal care, not care (mis)shaped by the current myriad of funding guidelines and constraints.

AHCRA believes that these structural changes to the way in which health care is funded is an essential precondition to enable a more consistent and equitable system to grow over the next ten years.

Other reforms

The following are also supported by AHCRA.

- Adoption of the casemix model, although we note that this will require extreme care in its implementation to ensure it does not adversely affect some hospitals and communities.
- The bringing together of funding for all primary health care services (e.g. general practice, community health) creates the opportunity for the development over time of one primary health care system. However the vision for this is very muted in the documents. The modest new primary health initiatives announced over the last year are all welcome (e.g. more practice nurses, funding of nurse practitioners, diabetes packages for enrolled consumers) but the vision for both a single system and the central role of comprehensive primary health care services (as recommended by the NHHRC) are all absent and force a more cautious approach to the appraisal of any initiatives.
- New, if very modest, spending on youth mental health, including the crucial area of early intervention. However this is an area with historic underfunding and the sector needs considerable building to successfully prevent, treat and assist in the recovery from all forms of mental illness.

- A raft of workforce programs which will increase the number of doctors in particular in the system in the future. (The proposals for other professionals are only modest by comparison, an unexplained bias.)
- Increased funding for aged care which is welcome and long overdue. However, AHCRA is concerned that the allocated funds will be insufficient to meet our community's growing demand for aged care.
- A new focus on national monitoring of quality of care and performance standards. This provides the potential to improve the overall standards of health care and to deliver increased transparency and accountability to health care consumers.
- The e-health initiatives do represent highly significant steps forward in facilitating both much stronger coordination of care and also safer care for consumers, especially around multiple medication use. The electronic health record proposals also enshrine and an increased level of control by consumers about their health information. The concerns of the consumer movement appear to have been addressed and AHCRA is very supportive.

3. Disappointments in the reforms.

However, AHCRA also has a number of concerns about the COAG reforms and their ability to deliver significant improvements in health care to the community.

Lack of guiding principles

We are disappointed that COAG did not articulate any underlying guiding principles or an overall agenda for health care reform. AHCRA believes that health system reform should be grounded in the values of the community and guided by principles that reflect community values. COAG's failure to articulate the underlying values of our health system make it difficult for stakeholders to assess the individual proposals in terms of their contribution to improving the health system overall.

Too much focus on hospitals

More specifically, AHCRA believes that the proposed reforms focus too much on hospitals, instead of providing major reform and an increased focus on primary health care and prevention. These sectors are the key to improving the health status of the community and reducing the reliance on hospitals in the future. AHCRA advocates a health system oriented around primary care and we believe that the COAG reforms will maintain the current centrality of hospitals within our health system, and hence a continued over-focus on the bottom of the cliff, rather than more humane, strategic and sustainable mending of the fences at the top.

Absence of any consumer focus

In addition, the reforms are currently too focussed around providers' needs and perspectives, rather than taking sufficient account of consumer preferences, priorities, and even fundamentally their position within the system. For healthcare to be truly consumer-focused, consumers need to be involved in the governance, accountability and performance of health system bodies, not simply recipients of provider decided actions. This has not been acknowledged, especially in the scant detail about whether there will be real consumer involvement in the Hospital Networks or the Medicare Locals. It would be scandalous if there was not.

Citizen engagement, participation, patient activation and empowerment must become core values at all levels of the health system. Health systems must equip patients with needed information, motivation, and skills in prevention and self-management. This is one of the WHO's key essential elements of action for improving health systems.

Similarly primary health care reform needs to be accompanied by corresponding investments in health advocacy and health literacy. These initiatives facilitate and support consumers' voicing their perspectives and contributing to quality health decision-making at individual, service and systems levels. Indeed, in the future, we wish to see the fostering of new and innovative models of "lifestyle" health care which will require the patient and the provider to "co-produce" health care and health outcomes.

A national multi-dimensional consumer advocacy and engagement framework implemented locally would facilitate such a shift but there are no decisions at all in the Agreement that would see any move in increasing consumer participation within the system.

Medicare Locals

The valuable role of divisions of general practice is acknowledged, and the potential of Medicare Locals to play a similar role in supporting and reforming the entire primary health care system is similarly recognised by AHCRA. However the current design of the organisations is yet to be finetuned enough to be practical and effective. They have too many roles currently (from support to reform to service delivery to funding allocation, many of which are incompatible with each other). A funding organisation cannot allocate funds to itself or be compromised almost entirely of potential recipients of funds. Further there seem to be structural problems in building the new Medicare Locals on the foundations of divisions, not least because of the legal issues inherent in the assumption that Divisions will hand over their roles and assets to the new entities. The concept needs some finetuning to enable it to be effective.

Gaps

There are two key aspects of this, the first being access to, and affordability of, care. The current mal-distribution of primary health services, especially general practices, is not addressed seriously enough. Although the Medicare Locals will have a planning role (and this is the first time such planning will have occurred) they appear to have few substantial levers with which to create a service system that maps services accurately against the where the population lives, and funds new services to create equity accordingly. This is a real deficit. In addition, the issues of out-of-pocket expenses (which accounts for up to 30% of health expenditure) and equity are again substantially ignored, and hence affordability, a key consumer concern in virtually every research study on consumer needs, is ignored.

Second, there are some really key areas of the health system have not been acted upon by COAG, including dental care (where the above issues of affordability are acute), Indigenous health, and inefficient subsidies for private health insurance. Without these, the potential for the COAG proposals to improve the overall functioning and equity of our health system is clearly reduced.

For many of the reforms proposed, there is too little detail provided for AHCRA to evaluate their potential impact. AHCRA urges COAG to provide additional detail on the reforms, in particular the proposed implementation process, as soon as possible. We also advise that consultation with stakeholders, including consumers, on the implementation of the reforms is essential to ensure their success.

Appendix 1 – AHCRA membership April 2010

Allied Health Professions Australia
Audiology Australia
Australian College of Ambulance Professionals
Australian College of Midwives
Australian College of Nurse Practitioners
Australian Council of Social Service
Australian Federation of AIDS Organisations
Australian Healthcare and Hospitals Association
Australian Health Promotion Association
Australian Lactation Consultants Association
Australian Nursing Federation
Australian Rural Health Education Network
Australian Women's Health Network
Australian Wound Management Association
Centre for Clinical Governance Research in Health
Chiropractors' Association of Australia
Choice
Chronic Illness Alliance
Consumers Health Forum of Australia
Continence Foundation of Australia
Country Women's Association Australia
CRANApplus
Doctors Reform Society
Frontier Services
Health Care Consumers' Association (ACT)
Health Consumers Network
Health Consumers of Rural and Remote Australia
Health Issues Centre
Health Reform South Australia
National Council For Intellectual Disability
National Federation of Parents, Families and Carers
Gordon National Rural Health Alliance
Michael Public Health Association of Australia
Public Hospitals, Health and Medicare Alliance
Royal Australian College of General Practitioners
Royal Australian College of Physicians
Rural Doctors Association of Australia
Rural Nursing and Midwifery Faculty of the RCNA
Services for Australian Rural and Remote Allied Health
Tasmanian Medicare Action Group
The College of Nursing (NSW)
Victorian Medicare Action Group

Total = 42.

Appendix 2: Key issues in current health system

The consensus among AHCRA's diverse membership has consistently been that there are a range of very significant system-wide issues that need addressing urgently, the foremost of which are the following.

1. AHCRA strongly believes that the changes required are for long-term improvement and sustainability, not short-term gain.
2. Most importantly, the gap in life expectancy between Indigenous peoples and the rest of the country is still a national disgrace. This requires action not just in health care but in all the social determinants of health.
3. There is no one 'health system' in Australia, but multiple health care systems in any jurisdiction and it is only the consumer that sees and experiences them. Thus the 'health system' in any jurisdiction, as in every other, is in reality only part of the 'system' that consumers have to understand and navigate. For example the primary health 'system' really comprises the GP system (funded by the Commonwealth), the community health system (by the State), public hospitals (State-run, jointly funded), and the private medical and allied health sector (not really a system at all). This mishmash is not only highly confusing for consumers, but also creates much fragmentation and inequality of access. No one government currently has responsibility for funding and coordination all these, but it is the consumer that experiences this unwelcome variation and fragmentation in access, structure, care, and out-of-pocket costs.
4. This is particularly so in primary health care. The ageing population and growing number of people with chronic disease (among other factors) require a much stronger, more accessible and better coordinated primary health care sector. It is currently too often poorly coordinated, fragmented and confusing. As one example, current best practice suggests that an Australian with diabetes should receive at least regular GP care, ongoing medication, regular blood tests, nutrition advice and education, education and support for self management, and annual feet and eye tests. For many Australians this is currently not available in one spot (or even two or three) but in multiple locations, by multiple providers working under different funding, with varying eligibility conditions and charging different fees with different out-of-pocket expenses for the consumer. Additionally there is no common medical record for all providers to access and ensure coordinated (and safe!) care.

This fragmentation of separate services and even systems militates strongly against consumers getting optimal care and adds inefficiency into the system, often involving costly but preventable hospital care. In AHCRA's opinion, this can only be overcome if there is one primary health care system. Such a system should certainly include universally accessible oral health care, even in the short-term.

5. Such fragmentation of separate systems means Australia offers very unequal and inequitable access to, and outcomes from, health care ranging from excellent to poor. For AHCRA, this inequity is the major issue requiring reform.

All consumers pay tax through the same rules, but do not get equal access and value. The fragmented sectors, funded by different governments each using different eligibility and cost criteria, are one major cause of this, as is the maldistribution of services (especially in primary health). This latter factor is most evident in areas of lower socio-economic status (including health status) and in rural areas.

6. There is near universal agreement on the need for a stronger focus on prevention. Many governments reflect this rhetoric but overall the responses to date have been highly inadequate, despite Australia's stunning successes in a few areas such as road accidents, smoking and HIV/AIDS. In these areas, many thousands of Australian lives have been saved and even more injury, disability and suffering prevented. Additionally of course, such action has saved all taxpayers billions of dollars in (now unnecessary) health care. These provide excellent examples where hospital care can be seen as evidence of society's failure to prevent illness or accidents or to treat conditions early enough at primary health care level.
7. AHCRA considers that much stronger consumer participation is required throughout health services to enable care, and more critically outcomes, to be more consumer-focussed and hence effective. This issue is acknowledged by the NHHRC but its recommendations are weak, as are those of the National Primary Health Care Strategy paper and report. This is a key issue, as is the associated issue of health literacy, and they both need addressing in a systematic manner, across all levels of the system. Considerable expertise exists to facilitate this but it has not been utilised to develop strong and feasible recommendations.
8. There are significant workforce issues that need addressing. These have been well-documented, and although there have been a myriad of small piecemeal programs developed in recent years, some of which have undoubtedly been effective (or will be over time) there are still considerable shortages and significant structural issues to address to ensure the kind of well-trained, flexible and well-distributed workforce we need.
9. There are significant gaps in services in oral health (with enormous inequalities in access and outcomes) and mental health services needing urgent attention.