AMA QUEENSLAND'S

HEALTH VISION

PART THREE: REPRIORITISING CARE IN RESPONSE TO NEED

AMA QUEENSLAND

EXECUTIVE SUMMARY

AMA Queensland is pleased to present the latest chapter of the AMA Queensland Health Vision, the third in a series of five documents which will guide our advocacy efforts over the next five years.

In this chapter of the Health Vision, we consider how to reprioritise care in response to need. AMA Queensland knows our State is facing an epidemic of lifestyle related chronic disease. We know these diseases are largely affecting our most disadvantaged citizens, including the unemployed, Aboriginal and Torres Strait Islanders and refugees. Areas where generational disadvantage has become entrenched suffer high rates of type 2 diabetes, heart disease, stroke and chronic lung disease. Evidence also shows that our most disadvantaged citizens are experiencing higher rates of mental illness.[1]

Our doctors and clinicians are doing amazing work in regard to managing this deficiency, but clearly more needs to be done. AMA Queensland believes that in Queensland we must reprioritise our health care funding so our health system is refocused on patients' need and at the same time strives for greater equity and sustainability.

To achieve this goal, AMA Queensland believes **the Queensland Government should invest in a trial of a "Health Hub"** which would demonstrate the clear advantages of **reprioritising our health system into a patient-centred, coordinated care model**.

Health Hubs are based on the patient-centred medical home (PCMH) model and are designed to better coordinate the care of patients in the community; to improve the quality of healthcare in Queensland and to reduce future potential costs by reducing demand on hospital services. The medical home has been used extensively overseas, dating back to 1967, and trials of a PCMH are now underway in Western Australia and Victoria. This provides us with a growing body of evidence demonstrating the effectiveness and efficiency of the model.

In a PCMH, patients and their families have a continuing relationship with a particular General Practitioner (GP), who is supported by a practice team and clinical services within the area. The medical home coordinates the patients care and acts as a gateway to the wider health system.

Some would argue general practices in Australia are already doing all of this, which is absolutely true. Many Queenslanders are already receiving high quality care through their GP and other providers. As the Australian Centre for the Medical Home explains, in Australia, all medical homes are general practices but not all general practices are medical homes.[2] Making Health Hubs a reality in Queensland empowers our general practitioners to deliver an even greater service to their patients. And it gives patients a greater understanding of their own health care needs, leading to greater health literacy, better health outcomes and lower instances of chronic disease.

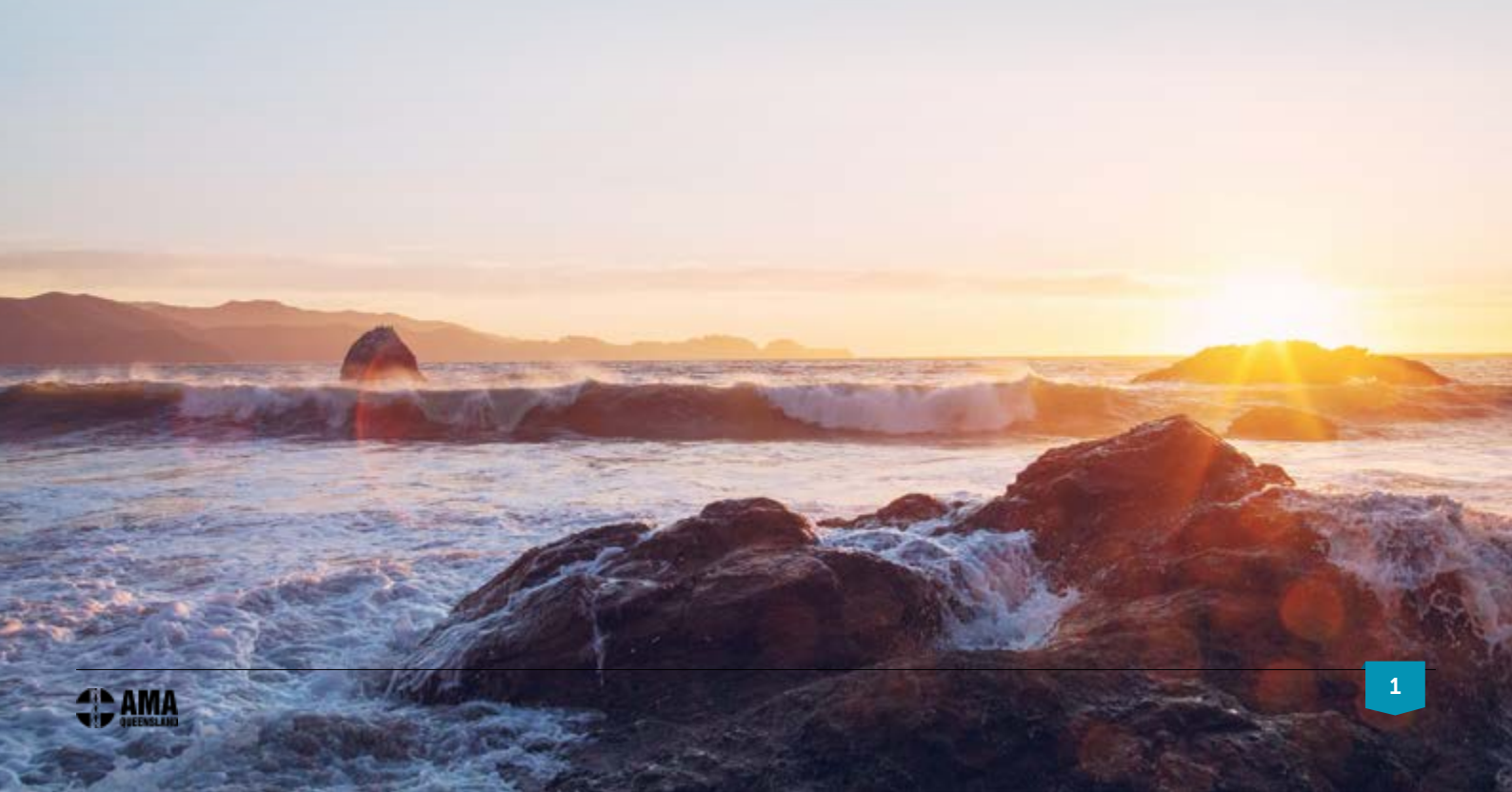
A PCMH would support reprioritisation in our health system, strengthening it into a patient-centred, coordinated care model. A trial of such a model would ideally fall under the auspices of a whole-of-government public health plan which we advocated for in Health Vision Part One: Public Health and Generational Disadvantage.

Once a whole-of-government public health plan and medical home has been established in Queensland, it opens up the possibility of further reforms, such as **expanding outpatient ambulatory care and the GP Liaison Program**. AMA Queensland believes these recommendations could, if implemented, lead to **Queensland having the lowest rate of potentially preventable admissions in Australia by 2020**.

Overcoming the challenges facing our health system will be difficult. It will take time. The fundamental challenge our health system faces is to ensure we continue to maintain our high standard of care while making the system more equitable and accessible. AMA Queensland believes implementing the ideas outlined in this section of the Health Vision will drive significant progress towards improving healthcare access and patient outcomes by 2020.

1 Australian Bureau of Statistics, National Survey of Mental Health and Wellbeing, Australian Government, 2007

2 Australian Centre for the Medical Home, The Medical Home – FAQs, http://medicalhome.org.au/faqs/



REPRIORITISING CARE IN RESPONSE TO NEED:

According to the Australian Institute of Health and Welfare (AIHW), expenditure on health in Australia was estimated to be $147.3 billion in 2012-13, up from $82.9 billion in 2001-02.3.[3] Governments funded 69.7 per cent of total health expenditure, a slight increase from 69.1 per cent in 2010-11. The largest components of health spending were public hospital services ($42.0 billion, or 31.8 per cent of recurrent expenditure), followed by medical services ($23.9 billion, or 18.1%) and medications ($18.8 billion, or 14.2 per cent).[4]

Queensland has witnessed its own health spending increase over time. This State spent $6.65 billion on health in its 2006 State Budget. Given the total size of that year's budget was $29 billion, this spend represented 22 per cent of the overall budget. By 2010, Queensland's Health Budget had risen to consume 25 per cent of the total budget, and by 2015-16, it was consuming 27 per cent of that year's $51 billion budget.

It is important to note, however, that all the money spent by the Commonwealth and State Governments on health is producing excellent results. Australia's performance and outcomes ranked highly amongst other OECD countries[5] . And while the majority of health funding is spent by the hospital system, the first port of call in the Australian health care system is usually the general practitioners office.

The latest Better the Evaluation and Care of Health Report (BEACH) data shows that in the April 2013–March 2014 year, just over 85 per cent of the Australian population claimed for at least one GP service from Medicare. Medicare paid rebates for about 126.8 million general practice service items (excluding practice nurse items), an average of 5.59 GP visits per head of population, or 6.57 visits per person who visited at least once. A decade earlier, total Medicare claims for GP–patient encounters numbered 96.3 million, an average attendance rate of 4.3 per head of population.[6]

This investment in general practice is providing excellent value for money. Although GP visits have increased, the services they are providing are more cost-effective when compared to other areas of the health system.[7] The average cost per service in a GP office is $47, whereas a visit to a specialist is an average of $82 and an ED visit can cost anywhere between $396 to $599.[8] When you factor in the results of a National Health Performance Authority report showing most Australians have a positive perception of care received from their GP, the value GPs currently provide to the health system is clear.[9]

When a visit to the GP isn't enough to make Australians better, our hospitals are relied upon. The National Health Performance Authority report shows they are also doing a fantastic job. This report, looking at Oct-Dec 2013, showed 80 per cent of patients in the highest performing emergency departments departed within four hours. Improvements were also seen among the lowest performing major metropolitan hospitals, increasing from 35 per cent to 51 per cent of patients departing ED within four hours from Oct–Dec 2011 to Oct–Dec 2013.[10] This is backed up by the AMA's 2015 Report Card on Public Hospitals, which shows that despite public hospital capacity not keeping pace with population growth, our hardworking doctors and nurses have managed to achieve some increases in services to patients. For example, in-patient care has increased by 3.3 per cent from the previous year, and out-patient care has increased by 7.2 percent from the previous year.[11]

This enviable performance is under threat on multiple fronts. The ageing population is a particular threat to this system. As the population ages, there will be fewer productive workers to support the health care of a growing proportion of older retirees. The cost of Information and Communication Technology (ICT) solutions in the healthcare sector is becoming increasingly expensive. Avoidable admission rates in Australia are higher than average amongst other OECD nations.[12] This alone suggests a need for greater primary care integration and coordination.

The latest BEACH data shows increased rates of chronic disease are also increasing demand on our GP sector. As Part One of the Health Vision showed, chronic diseases including diabetes and heart disease have a

greater impact on Australia's most socioeconomically disadvantaged citizens. While our universal health care system can effectively treat these conditions once they occur, out-of-pocket expenses mean that many socioeconomically disadvantaged Australians, including some Aboriginal and Torres Strait Islanders, refugees and the chronically unemployed, are missing out on these treatments due to lack of affordability.[13]

The way services are provided and funding is allocated has to change. Despite the excellent value for money being delivered by Australia's health professionals, our current health system cannot continue to fund an ever increasing demand for health care. While there may be a temptation to seek a quick fix to address the problem, these kinds of simple policy proposals will fail to achieve significant or long lasting results and may produce more harm than good.

For example, the co-payment model proposed by the Australian Federal Government in 2014-15 was criticized by the AMA and other stakeholders for having the potential to result in more vulnerable patients delaying or cancelling a visit to their GP, which could result in a compromised healthcare outcome and a higher cost burden to the health system. The co-payment as proposed (in both its forms) was a blunt instrument which, as a piece of public policy, failed to do the detailed policy work required to effect change. Instead, it simply placed a "catch all" price indicator to attempt to generate savings. While a co-payment policy may have potential value, the model put forward by the Federal Government failed to convince the health sector and the community of its benefit, which ultimately lead to its demise.

We raise the co-payment here not to be negative, but because it is worth remembering the lessons we learned from the saga. It aptly demonstrates how superficial policy initiatives fail to properly address the problems facing a health system as complex and multi-layered as the one we have come to rely on. Real health system savings can only be achieved with root and branch reforms.

AMA Queensland notes that recent public consultations (such as The Queensland Plan) have shown Queenslanders want a greater focus on public and population health and Closing the Gap. AMA Queensland also welcomes the excellent work of the Queensland Clinical Senate in promoting the best use of health resources in Queensland – an excellent example of the value of clinical leadership within the system.

Much more needs to be done to ensure health funding is prioritised in smart or innovative ways to meet the needs and values of the community. AMA Queensland believes the medical profession's values of service to the community, trust and knowledge should guide this process. Decisions should be made with access to a strong evidence base with effective guidelines (dictated by community values) to outline which areas of care will provide the highest value to the community and to patients. This should be done through a transparent and independent process and consultation with clinicians and other health stakeholders.

3 Health expenditure Australia 2012–13. Health and welfare expenditure series no. 52. Cat. no. HWE 61. Canberra: AIHW

4 ibid

5 AIHW 2010, How Australia's Health Compares with OECD Countries, http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=6442455435

6 Britt H, Miller GC, Henderson J, Bayram C, Harrison C, Valenti L, Wong C, Gordon J, Pollack AJ, Pan Y, Charles J. General practice activity in Australia 2013–14. General practice series no. 36. Sydney: Sydney University Press, 2014

7 Starfield, B, Primary Care and Equity in Health: The Importance to Effectiveness and Equity of Responsiveness to Peoples' Needs, Humanity & Society February 2009 33: 56-73

8 Britt H, Miller GC, Henderson J, Bayram C, Harrison C, Valenti L, Wong C, Gordon J, Pollack AJ, Pan Y, Charles J, Medicare Spending on General Practice is Value for Money, https://theconversation.com/medicare-spending-on-general-practice-is-value-for-money-33948, November 2014

9 National Health Performance Authority 2013, Healthy Communities: Australians' experiences with primary health care in 2010–11

10 National Health Performance Authority 2013, Hospital Performance: Time patients spent in emergency departments in 2012 and 2013 (Update)

11 AMA Public Hospital Report Card 2015, p.4

12 OECD (2013), Health at a Glance 2013: OECD Indicators, OECD Publishing. http://dx.doi.org/10.1787/health_glance-2013-en

13 Australian Bureau of Statistics, National Survey of Mental Health and Wellbeing, Australian Government, 2007

AMA QUEENSLAND'S VISION FOR REPRIORITISING CARE

Whilst Australia has been relatively successful in some aspects of preventative health, such as reduced smoking rates, high vaccination rates and low trauma rates, the obesity epidemic alone shows more needs to be done. The challenge we face is how to reprioritise funding within our health care system to embed prevention and early intervention for chronic lifestyle related diseases to a far greater degree than is already occurring.

Simultaneously, we need to ensure equitable access to care and treatment for all patients, regardless of their socio-economic status.

AMA Queensland believes there is a way to do this, but it will require a deft hand with input from clinicians and other medical staff, stakeholders and government. It will also need time, which means a bi-partisan approach is required to ensure that it survives the three year electoral cycle of Queensland politics.

AMA Queensland believes the solution lies in strengthening the role of primary care, focussing on secondary prevention and keeping people out of hospital as much as possible. We propose, as part of the whole-of-government public health plan proposed in the first chapter of the Health Vision, the Queensland Government considers establishing a patient-centred medical home model in Queensland.

The final report of the National Health and Hospitals Reform Commission (NHHRC) recommended a strategy where patients at risk of chronic disease should voluntarily enrol with a primary health care provider as their "health care home."[14] Although reform of the Primary Care sector is largely a Commonwealth responsibility, the Federal Government has, to date, not taken up the NHHRC's recommendation.

This does not preclude the States from trying to establish a PCMH model, however. AMA Queensland is encouraged by the CarePoint trial being undertaken in Victoria and Western Australia. The CarePoint model is a partnership between Medibank Private and the State Governments. The trial aims to place the GP at the centre of coordinated care with additional resources to help them facilitate the increased workload. This PCMH model includes an offsite phone-based Care Navigator, to help manage patient journeys between service, a Hospital Liaison Officer, to help manage post discharge administration, and a designated nurse working within the practice to help actively manage involved patients.[15] Such a model could help facilitate the medical home by the utilisation of economies of scale.

The PCMH is centred on the voluntary registration of patients with chronic health conditions and general practitioners. Once a patient suffering from a chronic health condition is registered by a general practice, it allows the treating GP to act as their central health co-ordinator, improving the patient's coordination of care. It also creates a unique long-term relationship between general practitioner and the individual patient. This relationship allows for an integrated, continuum of care involving nurses and allied health professionals. It would also allow the practice to implement long term evidence-based preventative health programs to help reduce the future impacts of further deterioration in the chronic disease condition.

There is an international basis for the development of the PCMH as an alternative approach to providing comprehensive patient care through a stable and ongoing relationship with a general practice.[16] The model, originally trialled in US Paediatric Care in 1967, has produced significant measurable benefits in providing improved patient-centred care. Notably, this can result in a reduction in avoidable hospital presentations (32-40 percent drop), hospital admissions (16-24 per cent drop), and length of hospital stay (36 per cent drop) in patients suffering from a chronic disease.[17]

The Victorian Carepoint trial shows that many GPs would be willing to rise to the challenge of this change. In the trial location, 85 per cent of GPs signed on to participate in the trial. Those practices that declined to be involved usually did so because they had computer systems that were not up to the standard required of the trial.

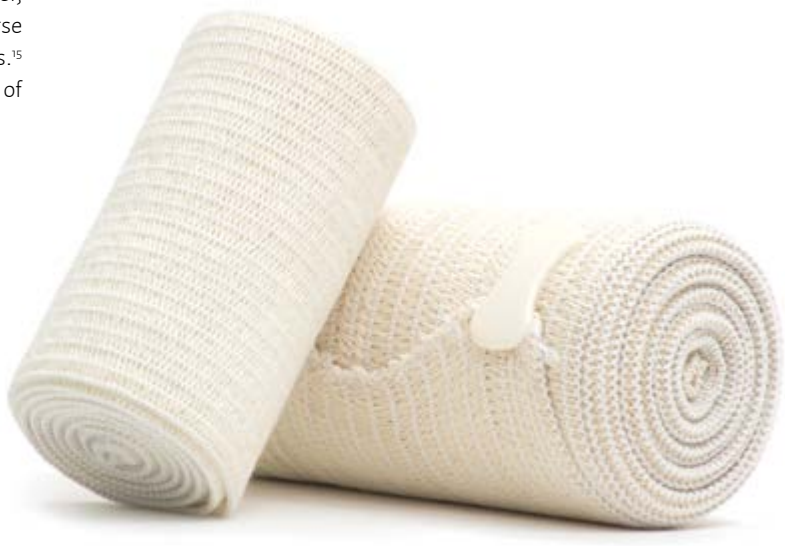
There is an appetite and a need for a PCMH in Queensland. In the absence of any move by the Commonwealth to reform the primary care sector, the Queensland Government must consider ways in which it can drive its own positive change.

14 National Health and Hospitals Reform Commission, A Healthier Future for All Australians – Final Report, http://bit.ly/1EZBXXx, Australian Government, June 2009

15 AMAVIC Report on Medibank Carepoint

16 RACGP, RACGP Submission to the Minister for Health, 2013-14 http://bit.ly/1SLIObW

17 ibid



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TARGET ONE

BY 2020, A MAJORITY OF QUEENSLANDERS WILL BE ENROLLED IN A HEALTH HUB AS THEIR MEDICAL HOME

If Queensland is to have a medical home system in place by 2020, we believe the first step is to implement a whole-of-government public health plan for Queensland.[18] We note that since the release of Health Vision Part One, the Hunter Review has also recommended the development of an overarching public health plan for Queensland[19] . AMA Queensland is pleased to see the Hunter Review has recognised the merits of this proposal and should the Government accept this recommendation, we look forward to working with them on its implementation.

As part of the development of this overarching plan, AMA Queensland argues provisions should be made for a trial of the patient-centred medical home in Queensland, to be called Health Hubs.

Health Hubs in Queensland should;

- Encourage patients within the trial area to enrol in the Health Hub, and educate them on the benefits of having their own GP; a medical home
- Support shared care with general practitioners through improved communication and education
- Work with primary care networks to support the development of 24 hour community care
- Work with primary care networks and AMA Queensland to develop community based emergency care centres that work collaborative with local GPs to reduce the burden on hospital EDs
- Develop integrated approaches to telephone advisory services and emergency dispatch centres to ensure patients have access to the correct type of service
- Upgrade IT systems to allow better access to information by shared providers

Conducting a trial of the Health Hub model before rolling it out across Queensland is a necessary first step to ensure we develop the model optimal for Queensland. This will allow the Government time to ensure the IT and funding solutions needed to support the trial can be properly developed and implemented.

We understand the cost of the CarePoint trial in Victoria is approximately $8 million over two years, with the costs divided equally between the Victorian Government and Medibank Private. AMA Queensland believes that given the costs of the Health Hub trial in Queensland would be comparable to the Victorian Carepoint model, therefore the Queensland Government should consider implementation without the involvement of a Private Health Insurer. This would help alleviate any concerns within the primary care sector around managed care and the prioritisation of privately insured patients, and help encourage more GPs to participate.

The CarePoint trial showed the costs of moving to a PCMH model could put a significant strain on some GP practices. A review of the challenges associated with properly implementing a medical home model in Australia showed that some Australian general practices would encounter difficulties with moving to a new patient-centred system, adopting electronic health records and adapting their payment models to suit[20] . The Queensland and Federal Governments should therefore examine a pragmatic range of solutions to ensure Queensland's Health Hubs can function effectively. At the outset, this would involve reprioritising funding to appropriately resource any practices which require extra support to transition to the new model. This may require an additional initial investment, but will ultimately be cost neutral as other efficiencies are found within the health system.

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18 See AMA Queensland's Health Vision Part One: Public Health and Generational Disadvantage located here: http://bit.ly/1CuhJAE

19 Hunter, R, Review of the Department of Health's structure, governance arrangements and high level organisational capability – Final Report, June 2015, Queensland Government, Brisbane

20 Janamian, T, Jackson, C.L, Glasson, N, Nicholson, C, A systematic review of the challenges to implementation of the patient-centred medical home: lessons for Australia, Med J Aust 2014; 201 (3 Suppl): S69-S73.

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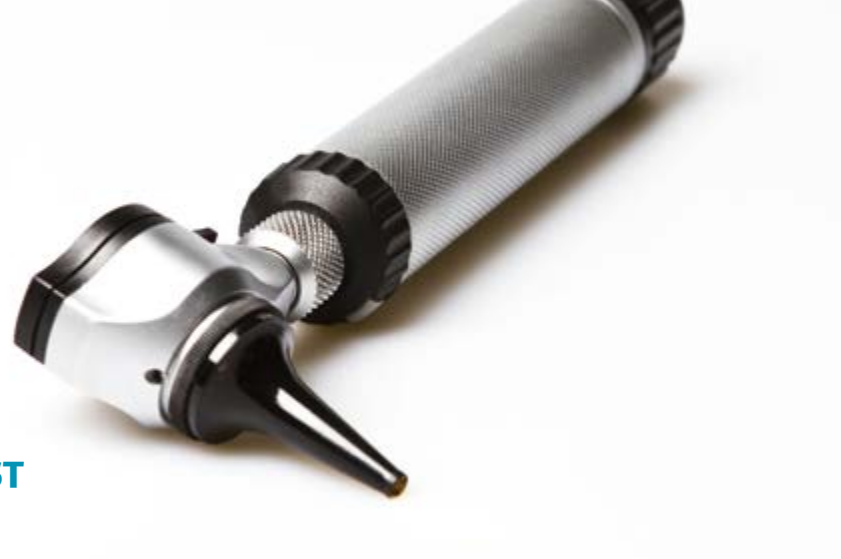
TARGET TWO



BY 2020, QUEENSLAND HAS THE LOWEST RATES OF POTENTIALLY PREVENTABLE HOSPITALISATIONS IN AUSTRALIA

After Health Hubs have been established in Queensland, our State will be on track to having the lowest rates of potentially preventable hospitalisations in Australia.

While Health Hubs will play an important part in reaching this target, more will need to be done to make sure we reach this goal. With the medical home functioning as the 'captain' of the patient's healthcare journey, it will help patients navigate the health system and call upon other parts of the sector, such as private and public hospitals, preventative health and sub-acute ambulatory care. To this end, AMA Queensland recommends the Government implement the following spending initiatives.

Improve Access to Paediatric Care: One vital component of meeting this target requires the Government to ensure paediatric care is given a special focus. The reasoning behind this special focus is the body of evidence which indicates failures of health care during a child's development can create lifelong deleterious consequences. If we aim to reduce the burden of chronic lifestyle related diseases on our health care system in the future, we need to ensure paediatric care is properly resourced to start affecting change immediately. Unfortunately, a 2012 study showed paediatric care in Queensland had significant barriers to access, such as equity in access to services, a lack of funding and resources, a lack of respite options and poor communication between services.[21] AMA Queensland urges the Queensland Government to do all it can to remove these barriers, ensuring Queensland's children are given the best possible start in life.

Expanding Ambulatory Care: Ambulatory care entails diagnosis, investigation, management, treatment and rehabilitation delivered in a community care setting. It can involve teams of medical and allied health specialists working with patients in a community setting or in their home. An example of a successful model is the Hospital in the Home program that was pioneered and refined in Victoria to provide acute care in the home. The program was found to have high levels of adoption and patient satisfaction as they were able to receive treatment in a comfortable setting.[22]

There are considerable benefits to appropriately resourcing sub-acute ambulatory care services through the reduction in utilisation of acute care facilities. An example given by our members is the treatment of patients at risk of falls in the sub-acute ambulatory setting. If they are able to receive the correct support, and treatment that helps mitigates these risks, then an extended stay in an acute setting could be avoided. An excellent example of this is attempting to reduce re-admission rates for people aged 65 years and older by reducing the falls risks that contribute to 75 per cent of total injury hospitalisations in this age group.[23] By improving access to falls services, through the medical home, this risk can be managed in the community context without causing the patient distress.

These services should be appropriately resourced, funded and staffed to ensure the maximum benefit is available to the broader healthcare sector. We call on the Queensland Government to argue for greater funding from the Federal Government for expanding ambulatory care. AMA Queensland will also advocate for this at every available opportunity when we meet with Federal Government representatives.

AMA Queensland believes all doctors should be able to refer their patients to these services in a timely manner. AMA Queensland also supports the expansion of funding models to allow a wider range of specialists to work in these services to provide greater value to those who utilise them. By connecting these services to the medical home the patient will be able to access these services as necessary, as part of a co-ordinated strategy, to improve outcomes for patients and reduce the preventable hospital admissions to the lowest level in Australia.

Expand the GP Liaison Program: Even when Health Hubs manage patient needs effectively, there will be circumstances where hospitalisation will be unavoidable. Given the historical divide between the primary and tertiary health sector, the Queensland Government has committed to the GP Liaison model whereby skilled primary health physicians use their experience to help the sectors work together more effectively. The benefits of dedicated general-practice integration are significant, optimising patient hospital usage, improving communication between the sectors and addressing 'long wait' patients awaiting specialist outpatient appointments.[24] They can also help streamline system design in acting as the interface between the sectors.

AMA Queensland's Health Vision advocates for the GP Liaison program to be expanded, appropriately resourced and supported as a core component of the Queensland Health Sector. Through this certainty, the program can innovate and experiment to maximise the benefits available and establish best-practice models that can be rolled out across Queensland. This can ensure when a patient is to be admitted to or discharged from hospital, their journey through the health system is as seamless as possible. This serves the ultimate objective that hospital care, when it is required, is delivered at the right place at the right time as part of an integrated treatment plan to ensure all hospitalisations are appropriate and necessary.

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21 Bradford, Natalie; Bensink, Mark; Irving, Helen; Murray, Judith; Pedersen, Lee-Anne; Roylance, Julie; Crowe, Liz and Herbert, Anthony. Paediatric palliative care services in Queensland: An exploration of the barriers, gaps and plans for service development [online].Neonatal, Paediatric & Child Health Nursing, Vol. 15, No. 1, Mar 2012: 2-7

22 Deloitte Access Economics, Economic Analysis of Hospital in the Home, http://bit.ly/1JsyJPF, 2011

23 Van Roo, S, Johnston, T, Petersen, L, Readmission Rates for Fall-Related Injuries, Queensland Health, http://bit.ly/1APWqJo, Jan 2015

24 General Practice Queensland Limited (2011) Enhancing Integration: The General Practice Liaison Officer Model, 2011, General Practice Queensland Limited November 2011, Brisbane.

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