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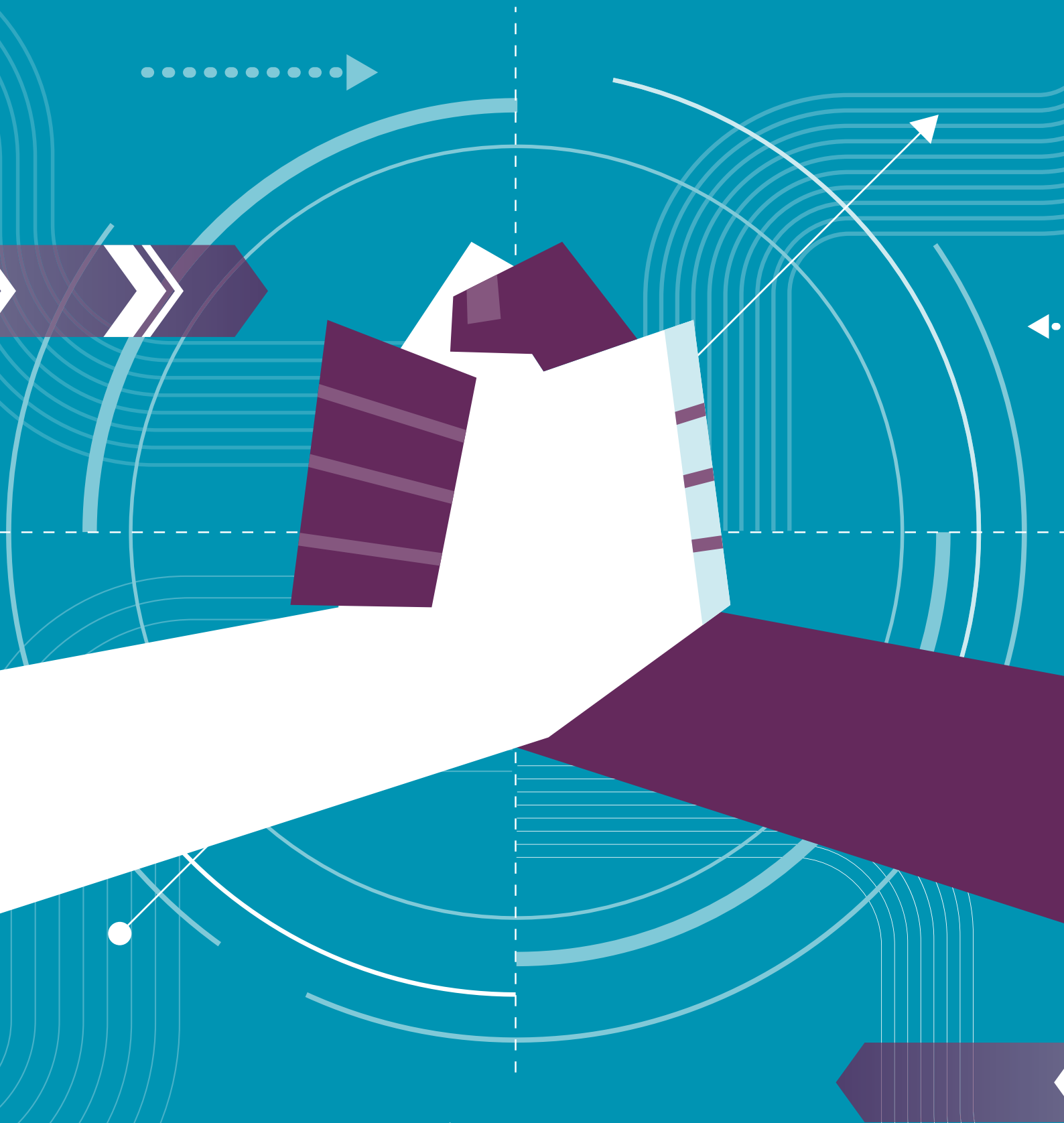
AMA QUEENSLAND'S HEALTH VISION

PART FOUR: UNIFYING AUSTRALIA'S HEALTH SYSTEMS



EXECUTIVE SUMMARY

Australia's health system is too complex, resulting in confusion for professionals working within the system and their patients. The distribution of responsibilities for health between different levels of government is blurred and unclear, resulting in duplication, cost-shifting and blame-shifting. The relative financial contributions of different levels of government to hospital services are fiercely disputed, especially when hospital funding arrangements are negotiated.

AMA Queensland believes many Queenslanders are tired of the blame game. We believe there is something more important than how these services are paid for. What matters most are patients and their health outcomes. It must always be remembered that a single patient is at the centre of this debate, and that person may be someone's mother or father or son or daughter. This is why it is vitally important that the Queensland Government looks at ways it can unify the health system as much as possible. In this, the penultimate chapter of the *AMA Queensland Health Vision*, we will examine how this can be achieved.

AMA Queensland and its members believe the answer can be found through improving connections between the primary, secondary and tertiary care sectors. To this end, Part Four of the *Health Vision* builds upon the targets contained in *Part Three: Reprioritising Care in Response to Need*.[1] In that section, we advocated for Queensland to introduce Health Hubs based on the patient-centred medical home (PCMH) model which would help guide patients through the health system, resulting in lower hospital admissions and helping to combat high rates of chronic disease. Once Health Hubs are operational in Queensland, AMA Queensland believes they will provide a foundation for improved collaboration between the health systems controlled by the Federal and State Governments, leading to higher quality health outcomes.

To achieve this target, we believe the Queensland Government should investigate how it can **improve connections between the different parts of the health system**. Until one level of government takes responsibility for funding the health system, improving connections is the only practical way to ensure patients can seamlessly navigate the primary, secondary and tertiary care sectors and improve health outcomes.

The *AMA Queensland Health Vision* has relied on best-practice research and the collective experience of our members in devising these targets which are necessary to ensure Queenslanders are able to navigate the increasingly fragmented health sector.

We hope to work with Government and other stakeholders on the implementation of the *AMA Queensland Health Vision* over the next five years and we commend this report to all who read it.

1 Download a copy of Health Vision Part 3: Reprioritising Care in Response to Need here: http://bit.ly/1zUOnjb

UNIFYING THE HEALTH SYSTEM

Anyone with even a passing interest in Australia's health system would be aware issues around health system funding are often dominated by cost shifting and blame shifting between State and Federal Governments.

The Australian story of health is one dominated by the divides between the Commonwealth and the states. The distribution of responsibilities and accountability are blurred and unclear, resulting in duplication, cost-shifting and blame-shifting.

The problems that plague our health system today are rooted, at least in part, in its early history. In a 2009 interview, Jim Gillespie, Deputy Director, Menzies Centre for Health Policy at the University of Sydney, told the Australian Broadcasting Corporation our health system has "some deeper structural problems, but [these] are much harder for governments to tackle. One is that our hospital system was really designed in the 1950s through to the '70s, to deal with problems of access that were left over from the '40s and '50s."[2]

From the 1900s to the 1920s, most hospitals in Australia were privately funded, usually through charitable institutions. As the cost of running private hospitals became more expensive, state governments started taking more control, bringing in intermediate beds and means testing for middle class patients.

The First Uniform Tax Case 1942 (Cth) dramatically increased the tax raising capacity of the Commonwealth and started the process of 'vertical fiscal imbalance' whereby the taxation bases of the states were steadily eroded. This process forced the heretofore self-sufficient states to become increasingly rely on Commonwealth funding to meet their responsibilities. Where the Commonwealth wished to provided funding for states to achieve health objectives, they were able to do so through the provision of tied grants, a process in which the Commonwealth would provide conditional funding with specific requirements as to what programs the funds were to be spent on.

In the 1970s, the Whitlam Government tried to tackle the issue of access to public hospitals by abolishing the means test. In 1975 the Whitlam Government introduced Medibank, the precursor to Medicare, which happened to coincide with a dramatic increase in the cost of hospital care. Later, a decrease in the amount of money coming to the states from the Commonwealth during the late 1970s and 1980s meant that the states could no longer expand the public hospital systems. This resulted in many beds and hospitals being closed and, arguably, the genesis of the "blame game" between the states and the Federal Government around hospital funding. Along with the shift in resources, there was also a centralisation of authority from hospital boards and clinical staff, to regional or area health services. As a result, community involvement in hospitals, which had previously been quite high, began to drop.

Today there is a complex division of responsibility for health care services in Australia, with many types of providers and a range of funding and regulatory mechanisms. Generally speaking, in the area of public hospitals, although the states and Commonwealth are jointly responsible for funding public hospitals, the states are responsible for administering public hospitals. It would seem the simple solution would be to develop a single funder health system. But this is easier said than done.

Part of the problem is that Australia currently has, in effect, eight different state and territory health systems. In 2010 the Rudd Labor

Government made some attempts to unify the health system, promising to fund "60 per cent of the efficient price of every public hospital service delivered in Australia," a fundamental change from its prior contribution of around 35 per cent. The Government touted the benefits of this increased financial stake, saying it would "put an end to the blame game over hospital funding." However, recent funding stoushes between the states and the Federal Government over health funding have shown that to be optimistic at best.[3]

Exacerbating these funding ambiguities is the increasingly outdated model of Australia's health system. Australia has a health system largely built around acute care, delivered through hospitals, on an episodic basis. Such arrangements struggle to keep up with the complexities of chronic care conditions that are increasing across Australia as they poorly manage the 'clinical handover' between the various fragments of the health system.

During development of the Health Vision, our members told us there were many disconnects between the different levels of the health system. Our members oft-mentioned a "silo" mentality, and that GPs working in the private system often felt isolated from those working in the public system. This fragmentation has had significant impacts on the quality of care delivered to patients with complex health needs. In Queensland there were 139,990 potentially preventable hospitalisations in 2011-12.[4] These are situations where hospitalisation could have been avoided if timely and adequate non-hospital care had been provided. Acute conditions were responsible for 50 per cent of these, with a further 47 per cent being a result of chronic conditions. Diabetes alone contributes to 14 per cent of all potentially preventable hospitalisations. While the proportion of potentially preventable hospitalisations was similar to the national proportion, the rate was significantly higher than the national rate. In particular, it was 10 per cent higher for chronic conditions and six per cent higher for acute conditions.[5] The end result is that Queensland has the second highest rate of potentially preventable hospitalisations across all jurisdictions. [6]

2 Quince, A, Public Hospitals, http://www.abc.net.au/radionational/programs/rearvision/public-hospitals/3168774#transcript, ABC, 2009

3 Dick, C, Abbott's $11.8 billion cuts to Queensland Hospitals, http://bit.ly/1HuOy1g, Queensland Government, 2015

4 Queensland Health. The health of Queenslanders 2014. Fifth report of Chief Health Officer Queensland. Queensland Government 2014

5 ibid

6 ibid

AMA QUEENSLAND'S VISION TO UNIFY AUSTRALIA'S HEALTH SYSTEMS

During the development of the Health Vision, AMA Queensland members signalled loud and clear that a single funder health system would be one way to unify the health system. And while a single funder health system could conceivably solve many of these issues, it was determined that this is outside the five year scope of the Health Vision. Unless a single funder health system suddenly becomes a reality, the practical solution to ending the blame game requires the Commonwealth and the states to find as many ways as possible to improve the way they work together and collaborate.

Ultimately, AMA Queensland is less concerned with who pays for the health system than we are with the outcomes that funding delivers. We believe Queensland must look at ways it can remedy this by improving the level of coordination and communication between general practice and the hospital system.

We have already made some recommendations that would help achieve this target in previous parts of the AMA Queensland Health Vision, such as the whole-of-government health plan outlined in Chapter One, and the Health Hub concept in Chapter Three. However, there are other ways in which the Queensland Government could remove duplication, improve efficiency and make a patient's journey through the health system much simpler.

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TARGET ONE

IMPROVED CONNECTIONS RESULT IN BETTER OUTCOMES FOR PATIENTS

The development of any new system should be built around the needs of people, rather than governments, providers or institutions. It should provide care that is quick and easily accessible, no matter where you may live. Increased transparency and strong performance reporting and auditing functions would, ideally, be cornerstones of a unified system.

As part of a suite of measures, AMA Queensland believes the Queensland Government should implement the following actions to help unify the health system.

Develop a state-wide, standardised, online pathway for GPs and patients which would allow them to track their position on the waiting list and the length of time to be waited: Patients and GPs in Queensland continue to experience difficulty in accessing outpatient appointments because a named referral is required for many clinics and there is no accurate way to predict waiting times. To remedy this, AMA Queensland believes the Queensland Government should begin a scoping study that would introduce an online referral and appointment tracking system.

The development of a state-wide, standardised online pathway for GPs and patients would allow them to track their position on the waiting list and the length of time to be waited and would help patients to make an informed choice about the type of care they access.

HHS & PHNs to work together to improve health outcomes for at risk communities: As discussed in previous parts of the Health Vision, generational disadvantage and lower socio-economic status have had a huge impact on some sections of Queensland's population such as;

- Aboriginal and Torres Strait Islanders
- Culturally and linguistically diverse (CALD) communities
- Lesbian, Gay, Bi-sexual, Transgender and Intersex (LGBTI) communities
- People with poor mental health and/or chronic disease
- People with a disability
- Refugees

Under the Hospital and Health Boards Act 2011 there is already a legislative requirement for HHS's to "use its best endeavours to agree on a protocol with local primary healthcare organisations to promote cooperation between the Service and the organisations in the planning and delivery of health services." Similarly, Primary Health Networks (PHNs) are also expected to develop collaborative working relationships with the LHNs (or similar) within their geographic area.

AMA Queensland believes these requirements could be utilised to improve connections developed as part of the Health Hub concept. Finding ways to formalise the relationship between HHSs and Health Hubs will help to improve coordination, identify gaps in service delivery to meet unmet need and prevent avoidable hospitalisations.

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TARGET TWO

INCREASED ENGAGEMENT BETWEEN GENERAL PRACTIONERS AND HOSPITALS

Increase HHS Engagement with GPs: The Queensland public hospital system is under pressure. One of the biggest complaints raised by members has been the poor communication between hospitals and primary care givers. In particular, GPs are not involved in the discharge planning of their patients from Queensland hospitals. This interrupts patient care and can make it harder for GPs to provide appropriate care for their patients. GPs do not receive adequate support when dealing with patients with special needs such as people with an intellectual disability, CALD communities or those who have poor health literacy. The GP or their staff may spend valuable time providing extra support to these patients as they navigate the hospital system.

Good relationships and communication between general practice and the hospital sector is an important factor in creating a seamless health system and reducing unnecessary referrals, and duplication of services. Hospital and Health Services should be required to effectively engage with GPs in their area and should develop an annual survey to measure their success. This GP engagement survey should be used as a KPI for measuring the performance of Hospital and Health Services. We also repeat our call for the General Practice Liaison Officer (GPLO) program to continue to receive funding, as outlined in Part Three of the Health Vision.

Create connections and training opportunities between General Practice and hospital care by implementing a further trial of the Physician/Psychiatrist in the Practice Model: A trial of this model was run by GP Connections, Toowoomba. The trial involved visits by physicians and psychiatrists into rural general practices to provide specialist care to patients and up-skill GPs. The evaluation of this study outlined educational gains for GPs and specialists, improved relationships and improved patient satisfaction. AMA Queensland believes further study should be undertaken into this program with a view to possibly expand it state-wide.

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