AUSTRALIAN HEALTHCARE & HOSPITALS ASSOCIATION

AHHA Pre-Budget Submission -

Federal Budget 2012-2013

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1. Introduction

The AHHA is the independent peak industry body representing the public healthcare and not-for-profit healthcare sectors. The following paper outlines eight critical issues of current concern to AHHA members and stakeholders in these sectors. Our members strongly believe that additional Commonwealth Government funding in these areas will enhance their capacity to deliver quality services to the community and ensure greater viability and sustainability in these areas. It is strongly recommended that the Government consider funding these important initiatives in its 2012-13 Budget.

2. National Health Reform: Integration of Services

2.1 Enhancing Coordinated and Integrated Models of Care

One of the major intentions of the National Health Reform is to strengthen primary healthcare through establishing Medicare Locals (MLs). MLs are charged with identifying the needs of local communities through detailed planning in collaboration with other service providers such as Local Hospital Networks and to meet those needs by providing targeted primary health care services, particularly for those with chronic conditions, mental illness and the aged.

To do this effectively, Medicare Locals will have to orchestrate a high level of service coordination and integration by connecting primary / community, secondary and tertiary health services within and across Local Health Network boundaries as well as health professionals working in teams.

This will be a complex and difficult task, the mechanisms and incentives for which are still not clear. However, evidence demonstrates that well coordinated and integrated care leads to the more efficient use of health care resources, reduced health service utilisation and higher patient satisfaction.[1] Studies clearly demonstrate that communication and leadership are vital to improving service integration, and that effective coordination depends on better utilising existing organisational structures rather than reinventing and applying new structures.[2,3]

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[1] McMurchy D (2009). What are the critical attributes and benefits of high quality primary healthcare systems? Report submitted to the Canadian Working Group on Primary Health Care Improvement. Canadian Health Services Research Foundation.

[2] McMurchy D (2009). What are the critical attributes and benefits of high quality primary healthcare systems? Report submitted to the Canadian Working Group on Primary Health Care Improvement. Canadian Health Services Research Foundation.

[3] Audit Scotland (2011). Review of Community Health Partnerships. Auditor General for Scotland and the Accounts Commission. June 2011

AHHA recommendation #1: A National Health System Coordination and Integration Program

That the Australian Government fund a **National Health System Coordination and Integration Program** designed to develop best practice in coordinated and integrated care across the boundaries of primary / community, secondary and tertiary health services including Local Health Network boundaries and between health professionals working in teams. The program would consist of three components - collaborative research, promoting the translation of research evidence into practice and supporting existing innovative practices.

Research Component: To support national research into the challenges associated with delivering coordinated and integrated care, taking into account existing practice in Australia. It would have a particular focus on collaborative research aimed at finding solutions to problems and translating research evidence into practice. A key focus of this component would be to identify innovative service models designed to improve the patient journey through the health system and which could be implemented on a nationally consistent basis.

Implementation Component: To foster the translation of research evidence on successful models of integrated care across a range of healthcare settings (in line with the Research Component above) by providing grants to selected health services (criteria to be developed). A key focus of this component would be to improve the patient journey through the health system and test nationally consistent models of coordinated and integrated care.

Evaluation Component: To ensure analysis and distribution of outcomes from the program. A key focus of this component would be the national application of an integrated system of care.

Projected cost and timeline

Components 1 & 3: Approximately $1.2 million in 2012-13.

Component 2: Approximately $3.3 million over two years. This is based on allocating 12 grants in both 2012 and 2013 at an average of $130,000 each per year.

2.2 E-Health: Enhancing Discharge Planning and Referral

The AHHA commends the Australian Government on its progress on e-health and its commitment to facilitating the transition from paper-based clinical record keeping to electronic platforms. Effective electronic transfer of information between hospitals and

primary healthcare / community services is vital for effective discharge planning and the management of people post-discharge, particularly those with chronic and complex diseases. Such a program would complement the National Health System Coordination and Integration Program described above.

However, due to the fragmentation of the health system, there are numerous information management systems in place (particularly in hospitals) with varying capacities for information collation and transfer which impacts negatively on integration of services.

Multiple studies have found that effective discharge planning processes require accuracy, completeness and timeliness. There is little reliable evidence that these factors are consistently evident in discharge planning across Australia.

A study from KPMG, for example, that examined the lead sites introducing the Electronic Discharge Summary Systems, found that the use of e-health technology for discharge summaries was not simply about making existing processes electronic.[4] Careful consideration also needs to be given to what constitutes best practice in the first instance. Implementing successful electronic systems requires considerable thought and planning around training, change management and consultation to ensure that they deliver improvements rather than entrench poor practice.

A recent study by the University of Tasmania, commissioned by the Australian Commission on Safety and Quality in Health Care and NSW Department of Health, examined discharge and referral practices in Australia.[5] It noted that:

- much of the research on discharge planning is hospital focused, which could lead to a misunderstanding that these processes are the sole responsibility of hospitals;
- discharge planning and referral were predominantly treated as independent processes and examined in isolation; and
- one of the most significant risks in discharge planning was medication safety and management, which is particularly relevant for the elderly, those with confusion or dementia, people with chronic and complex disease, patients on multiple medications, migrants with low levels of English and people with low levels of literacy.

NEHTA's e-Discharge Summaries Program will develop key specification requirements for software vendors, GPs and hospitals.

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[4] Australian Commission on Safety and Quality in Health Care (2011), *Safety and Quality Evaluation of Electronic Discharge Summary Systems Final Report.* ACSQHC. Sydney.

[5] Cummings E. Showell C. Roehrer E. Churchill B. Turner B. Yee K.C. Wong M.C. Turner P. (2010) Discharge, Referral and Admission: A Structured Evidence-based Literature Review, ***eHealth Services Research Group***, University of Tasmania, Australia (on behalf of the Australian Commission on Safety and Quality in Health Care, and the NSW Department of Health)

This program needs to be accompanied by strategies that support quality improvement and best practice discharge planning across the nation.

AHHA recommendation #2: A National Discharge Planning and Referral Program

That **A National Discharge Planning and Referral Program** be funded in order to develop and deliver national discharge planning protocols including quality standards, supported by electronic tools.

Projected cost and timeline

Approximately $3.6 million over 3 years

3. A Sustainable **F**uture for Multi-Purpose Services

There are 134 Multi-Purpose Services (MPSs) operating across Australia in rural areas, some of which have been using the model since its inception in 1991. There is no consistent approach or application of the MPS model, nor a clear strategy of how it will evolve into the future. Nor are there coordinated data on the outcomes of MPS operations across Australia, which makes it difficult to assess how effective they are at coordinating and delivering healthcare services for their whole community.

Some states are increasing the number of MPSs. A national evaluation of the current model will help ensure that the MPS model is applied more consistently. By comparing MPS and other small health services in rural areas, it would be possible to identify critical success factors to inform expansion of the program. Such an evaluation would include analysis of the current funding arrangements and other data from all MPSs.

AHHA Recommendation #3: A National Evaluation of the Multi-Purpose Service Model

That **A National Evaluation of the Multi-Purpose Service Model** be funded to identify differences in how services operate across jurisdictions including variations in governance structures, reporting processes and factors that have facilitated success. A key outcome of this evaluation would be to develop a standard evaluation and data collection framework for MPSs as well as to recommend improvements so the model may continue to better support an ageing population in rural and regional communities.

Projected cost and timeline

The estimated cost for the full evaluation of the MPS model, to be contracted to a high-quality collaborative research team (including academics and service providers) would be approximately $900,000 in 2012-13.

4. Indigenous Health and Cardiovascular Care

The health of Indigenous people in Australia continues to lag behind the rest of the Australian community. While improvements have occurred, including a small reduction in the life expectancy gap between Indigenous and non-Indigenous Australians, there are several issues that remain outstanding. They include access to timely and effective acute care for acute coronary syndrome.

The Heart Foundation and the AHHA have already developed a number of strategies designed to improve the quality of care Indigenous people with acute heart conditions receive whilst in hospital (*Better hospital care for Aboriginal and Torres Strait Islander people experiencing heart attack*, 2010). The Heart Foundation and the AHHA is developing a hospital demonstration and mentoring program that builds on research undertaken by the CRC for Aboriginal Health (*Improving the culture of hospitals)*. This program will require seeding and ongoing funding to ensure that it is successful.

AHHA Recommendation #4: A National Indigenous Hospital Demonstration and Mentoring Program

That **A National Indigenous Hospital Demonstration and Mentoring Program** be funded that focuses on Indigenous heart health in the first instance (as an exemplar for other chronic and acute conditions). Hospitals providing best practice care would be identified and assisted to impart their knowledge to other hospitals in the mentoring program.

Projected cost and timeline

The estimated cost for seeding the development of a hospital demonstration program in Indigenous heart health is approximately $1 million per annum.

5. Refugee Employment in the Health Services Program

There are sound reasons for employing refugees and migrants in health services. It provides benefits to the individual and facilitates social inclusion and social cohesion. Health services also gain from employing refugees because it enables them to fill skill and labour shortages. Young refugees who are educated and trained in Australia should be targeted as potential health service employees. Employing refugees also broadens the workforce demographic and develops a staff profile that reflects the cultural diversity of the wider community. It also makes it more likely that health care services will become more accessible to the local refugee population.

Very few refugees trained in health professions overseas will arrive in Australia with the clinical skills necessary to work here. Even those with the necessary skills and qualifications will, for the most part, need a period of adjustment in order to acquire the English and cultural skills.

Australian health services continue to work hard to meet the challenge of providing appropriate, equitable and accessible healthcare for refugees. Evidence shows that refugees newly arriving in Australia can sometimes experience difficulties accessing healthcare services due to language, cultural and economic barriers.[6] Further hurdles are sometimes created by health employees who are not adequately trained to meet the special needs of refugees.

While the Australian Government provides a number of settlement programs to assist refugees, training programs in English language skills are often not long enough for many refugees to become proficient. Language training programs also tend to be focussed on settlement, so they do not provide any specific training that could help someone gain employment in the health sector. As a result, the types of employment people can seek can be restricted and mean that many refugees take up unskilled and casual positions with limited career prospects.

By providing training positions in health services in rural and regional areas of Australia, refugees can be helped to settle in and secure stable employment.

AHHA Recommendation #5: A National Refugee Employment in the Health Services Program

That a **National Refugee Employment in the Health Services Program** be funded with two components.

Component 1: To develop **pathways for up-skilling refugees** in Australia, including those with overseas health qualifications.

Funding from the National Workforce Development Fund could be targeted towards initiatives that provide vocational education for refugees. Training options in the health sector include traineeships in administration, patient services assistants and health support services such as catering and cleaning.

Additional support should also be provided for refugees to undertake English language training so that they can reach the level of English required to be accepted into a minimum of Vocational Education and Training (VET) Certificate III level course in a health related area.

Component 2: To provide a **national mentoring program** for employment of refugees in the health sector. A mentoring program similar to the Australian Government's *Building Australia's Future Workforce* package would be funded from the National Workforce Development Fund. This would increase refugees' participation rate in the workforce and enable employers to provide the additional support to train refugees.

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[6] Murray S.B. and Skull S.A. (2005). *Hurdles to health: immigrant and refugee health care in Australia*, Australian Health Review, February 2005 29:1

Projected cost and timeline

Component 1: Approximately $3 million to train 600 refugees at Certificate III and Certificate IV levels over two years.

Component 2: Approximately $3.2 million over two years

6. Oral and Dental Health

The lack of action in oral and dental health is a major health policy concern of the AHHA. We commend, however, the establishment of the National Advisory Council on Dental Health. This is a step in the right direction for those Australians who continue to suffer because of limited access to affordable oral health care - pensioners, the unemployed, low income earners, Indigenous Australians and those in rural and remote areas.

Oral health is vital to overall health and well-being. Dental problems impact on people's ability to eat (affecting nutrition), socialise, find employment and fully participate in society. If untreated, dental problems can develop into more serious health conditions requiring intensive treatment and sometimes hospitalisation. While these problems are widely recognised, gum disease and dental caries still account for two of the top five public health issues in Australia. Dental care is one of a few elements of public healthcare that is not covered by the National Health and Hospitals Network Agreement or by Medicare.

Almost half a million people remain on waiting lists for public dental treatment, with an average waiting time of approximately two years. It makes no health, social or economic sense to allow people to languish without access to regular preventative dental care and treatment. Many people who start out on waiting lists for preventative or restorative treatment become emergency cases by the time they receive treatment. Often they 'choose' or are effectively compelled to have their teeth removed due to financial, staffing and other resource pressures in the system.

AHHA Recommendation #6: A Universal Oral and Dental Health Scheme for All Australians

That **A Universal Oral and Dental Health Scheme for All Australians** be funded over time, commencing in 2012-13. It would commence with services for those who need it most such as children, the elderly, people with chronic and complex disease and families on low incomes. It is recommended that the Australian Government absorb the Medicare Chronic Disease Dental Scheme and Medicare Teen Dental Program funding into the developing universal scheme and reflect the savings progressively.

Projected cost and timeline

$1,800 million in 2012-13 rising to $2,907 million in 2013-14

7. National Postgraduate Nurse Program and Nurse Graduate Support Teams

Postgraduate nursing programs have been available since 1996. Most research on these programs is focused on students' perceptions and expectations, and management views of students within the post graduate programs.[7] Little research has been done on the value of working as an entry level nurse. Up to a third of the entry level nurses will leave graduate programs due to a range of factors, including being overwhelmed by the pressures of their first year of nursing. These factors are strongly dependent on the clinical support provided to the graduates in that first year.

Some argue that entry level nurses should not be required to have a Bachelor degree and that nursing is all about the body and bedside manner. However research shows that patients have better outcomes in hospitals that employ more nurses with Bachelor degrees (or higher).[8]

Based on preliminary research undertaken by AHHA, it is apparent that there is little consistency in new graduate nursing programs across Australia. Graduate Nurse programs are offered in many facilities, but student numbers are often limited and the amount of support and content of programs varies widely. As a result, many people question the effectiveness of these programs. Currently, students may be studying in one state and then may choose to move to another state purely based on the benefits, including higher salaries. This also leads to a pull of graduates to the metropolitan areas and a shift in graduates away from the most needed areas, such as rural and remote parts of the NT and NSW.

There is evidence that Graduate Nurse Programs do not offer enough positions overall for graduating nurse entering the workforce.

A standardised, evidence based graduate nurse program for all nurses is needed in Australia encompassing a "Graduate Support Team". A critical aspect will be adequate clinical and mentoring support. Socialization into the professional setting (work environment) with hands-on clinical experiences and in-depth mentoring and support, increase both personal and professional growth and development. A new graduate support team is an excellent model to standardise across all hospitals, LHDs and states within Australia.

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[7] Manias E. (2005) Clinical teachers in specialty practice settings: perceptions of their role within postgraduate nursing programs, *Learning in Health and Social Care, 4*(2), 67-77

[8] Aiken, L., et al. (2003), Educational levels of hospital nurses and surgical patient mortality, *Journal of the American Medical Association, 290*(12), 1617-1623

AHHA Recommendation #7: A National Postgraduate Nurse Program

That **A National Postgraduate Nurse Program** be funded comprising two components.

Component 1: Development of a set of **standards and framework** for an evidence based graduate nurse program for all nurses in Australia. This program would establish standards for continued professional growth and development throughout the first year of nursing following graduation. It would reinforce conceptual learning and encourage in-depth clinical skills, enhance self-confidence and feelings of competency.

Component 2: Development of a national **Nurse Graduate Support Teams** program to provide for all new graduates to have access to a team dedicated to supporting them as they begin their career. This would strengthen graduates' commitment to nursing, provide a safe environment and support continuing professional development.

Projected cost and timeline

Component 1: Feasibility study for the model and design a model to pilot, including consultation: $750,000 over two years.

Component 2: Approximately $600,000 in 2012-13 to establish and then $1.3 million of funded projects in 2013-14.

8. A National Arts in Health Program

There has been increasing interest in, and scientific evaluation of, the impact of the visual, performing and literary arts on health, wellbeing and quality of life. Specific areas of endeavour include mental health, disability, ageing, chronic disease and health promotion.

The value of the arts and artistic expression as an aid in treatment of mental illness was internationally recognised at the 10th World Congress of Psychiatry in 1996.[1]

Qualitative and quantitative research supports the benefits of the arts and creative activities in primary and acute care, community health, health promotion and medical education, encompassing visual arts, (painting, sculpture, photography, film, digital media), music, theatre, dance, creative and narrative writing, across the lifespan. For example, arts programs for children have been evaluated and results show that children can cope more effectively with the aftermath and the emotional effects of disasters such as the earthquakes in Pakistan and Kashmir in 2006.[2]

A pilot study into the efficacy of creative arts interventions to enhance wellbeing in newly diagnosed breast cancer patients also show positive results.[3] In this study, researchers found that participating in the creative arts enhanced psychological well-being. Similarly studies have shown that arts interventions can reduce pain and other symptoms common to adult cancer patients.[4]

In 2009 the National Rural Health Alliance joined with Regional Arts Australia to support the publication of '*Seeded – great arts stories grown in regional Australia'*.[5] The publication documents 13 arts and health projects from rural, regional or remote Australia. They include the Tree project, a remarkable response to the disastrous Victoria bushfires; *Dust,* the theatre performance that brought home the issues of asbestos contamination to rural communities in Victoria; and the Cooma (NSW) multimedia project *Beyond Roundabouts* that addressed life challenges for young parents and won State and National Arts Health Foundation Awards in 2010. Also noteworthy is the Western Desert Kidney Health project which is helping to achieve significant preventive health outcomes in Aboriginal communities in Western Australia.

The '*Seeded'* projects above are examples of successful collaborations. There is a growing body of research evidence supporting the value arts and health collaborations have in improving patients' experiences and health outcomes. In a recent survey of 19 studies on this topic, researchers concluded that creative engagement could decrease anxiety, stress, and mood disturbances.[6] The study also recognised that much of the research in this area to date has been conducted in hospital and healthcare settings, rather than community settings. The *Seeded* projects provide evidence that programs do not need to be limited to clinical or institutional settings to have beneficial health outcomes. However there is a need for further research into the benefits of such programs.

AHHA Recommendation #8: A National Arts in Health Program

That **A National Arts in Health Program** be funded with two components.

Component 1: **Arts in Health Research** focusing particularly on programs that improve the lives of aged people and those with dementia. Many aged care facilities utilise such programs and the award winning Aldergate Uniting Care Wesley program in Adelaide has received international recognition. Such research will add valuable knowledge needed to support future programs that may reduce health costs and burden in the long term.

Component 2: A **National Approach to Arts in Health Programs** which recognises the value of Arts in Health programs and provides funding for projects that:

- Showcase best practice Arts in Health programs for patients including those with cancer, dementia and mental illness and aged care;
- Increase the capacity of aged care and health care providers or community services organisations to provide such programs with trained and skilled therapists and arts professionals;
- Increase partnerships / alliances to enable communities to develop their capacity to utilise creative arts programs to deliver health-promoting lifestyles.

Projected cost and timeline

Component 1: Approximately $2.5 million over 2 years.

Component 2: Approximately $1.2 M over two years