Australian Healthcare & Hospitals Association
2009-10 Federal Budget Submission

1. Community Engagement in Healthcare Policy Decisions

Currently, there is no systematic process to obtain the views of the Australian community on their healthcare system including the allocation of health care resources. The AHHA believes that greater community involvement will result in more effective and responsive health policies and strongly promotes the need to involve consumers in the planning, implementation and evaluation of health policies and programs.

The AHHA recommends that the Australian Government:

- Undertakes a research project to determine how best to engage with the community on planning, implementation and evaluation of health policies and programs, including resource allocation, with the view of forming a *National Consumer Engagement Strategy*.
- Such a strategy should include:
    - the views of the whole community including marginalised groups. This is particularly the case for multicultural and Indigenous populations for whom "traditional" models of engagement may not be appropriate;
    - consumer participation in accrediting health agencies and assessing health facility performance; and
    - ensuring consumers have access to comparative performance assessments (appropriately risk adjusted) against criteria that are relevant to them.

Cost:
The AHHA recommends outsourcing the research project to an appropriate university or organisation over a 1-year period to provide recommendations and costing for a *National Consumer Engagement Strategy*. The estimated cost is **$1.05 million in 2009-10**.

2. Data and Benchmarking

The AHHA proposes that the experience of patients as well as the technical quality and technical efficiency of the health care system should be systematically monitored at a national level through measurement, analysis, benchmarking and reporting to funders (initially Commonwealth and State Governments), providers of health services, clinicians and ultimately to the community. The AHHA defines the health care system as including all sectors: health promotion, primary, secondary, tertiary, rehabilitation, community and institutional services, care of acute and chronic conditions and public and private services.

The AHHA recommends that the Australian Government:

- Strengthens the role of the Australian Institute of Health and Welfare (AIHW) to give it greater capacity to:
    - process outcome data from state/territory governments and healthcare facilities and to provide an independent analysis of that data for reporting in a timely fashion to governments, community and other stakeholders. To undertake this role effectively, the AIHW would require live and direct data flow from healthcare services simultaneously with provision to state/territory governments plus access to MBS and PBS. This information should be nationally standardised to create effective linkages and benchmarking opportunities between sources of health information from state/territory, regional, and local levels; and
    - undertake high level scientific research and evaluation on the measurement and improvement of patient care, health status and outcomes. In this context, the AHHA recommends commissioning the AIHW to undertake a stock-take and evaluation of data collected and information presently available to support performance monitoring and benchmarking of health care services and of all components of the healthcare system.

    Cost:
    The AHHA recommends funding of a team of researchers in the AIHW to undertake the data analysis, research, evaluation and stocktake including a national consultation program with the state/territories. The estimated cost is **$1.08 million per year (total of $2.9m over 3 years)**.

3. Information management

From being an early leader in its ability to manage and use health information, Australia is now increasingly falling behind comparative countries such as the UK, Canada and the US. The Australian Government has a critical role in establishing the policies, programs and health information infrastructure needed to address this situation. The recommendations put forward by the AHHA address this growing gap and are consistent with recent broad Australian Government undertakings, specific ALP policy and the Principles of the newly established National Health & Hospitals Reform Commission.

There are some discrete programs that could help in the short to medium term that offer high value at relatively low risk. The AHHA recommendations should be seen in the context of them being a prelude to a major set of undertakings that will require comprehensive planning and strong stakeholder engagement to succeed. It seems clear from the experience elsewhere that substantial initial investment is required before returns are seen but once this investment threshold is passed the returns far exceed the costs.

The AHHA recommends that the Australian Government:

- Accelerate the current health information infrastructure work program, establishment of clear milestones and provision of routine reporting to the community on progress.

  Cost:
  The elements of the current health infrastructure work for which the National Electronic Health Transition Authority (NEHTA) has responsibility appear to be adequately funded with NEHTA reporting under-budget expenditure. Additional funds may be required to extend coverage of broadband from that already dealt with by the Government's National Broadband election promise which undertakes to provide 98% coverage. While 98% probably addresses all substantial points of healthcare delivery, **$20 million may be required to handle outlying facilities for broadband access**. A one off payment of **$10 million in 2009-10 should also be budgeted to fund the development of interoperation between current health communication providers**.

- Fund the national standardisation of existing messaging for pathology and radiology for both public and private sector and use this as a communication backbone to the community for subsequent upgrading and expansion including for transfer of care documents (discharge summaries, clinical letters, specialist referrals).

  Cost:
  It is estimated that this program would cost around **$20 million to establish in (2009-10) and around $10 million per annum recurrent expenditure**. It is proposed that the recurrent funding be paid on an outcomes basis (ie. per conformant message) and that these arrangements be integrated into the current governance arrangements for regulation and funding of pathology and radiology services.

- Fund the development of common registry services to measure activity and outcomes for clinical, public health and surveillance purposes that can be used locally, and at the State / Territory and national levels.

  Cost:
  Based on current cost estimates of $4 million per registry in establishment costs and around $2 million per annum in recurrent expenditure and given the range of registries that would need to be accommodated there would be an **initial establishment cost of more than $200 million in 2009-10; but with subsequent savings against current and future expenditure this may reduce considerably**. Clear benefits, in both direct costs and indirectly in areas such as reduced patient suffering and re-operation, have already been demonstrated with the Joint Replacement Registry among others and it is expected these benefits would be consistently obtained following implementation of the program.

- Fund the development of a National Library for Health that provides quality-assured timely knowledge to all Australians in electronic form.

  Cost:
  An initial project definition and procurement project cost of $2 million in 2009-10 followed by ongoing knowledge delivery estimated at $20 million pa.

- Government must support and where necessary fund the development of a national consensus plan for effective management of health information, which is resourced and has governance arrangements that are widely supported by both the private and public sectors. AHHA is a member of the Coalition for e-Health which is comprised of most of the organisations currently involved in e-health in Australia. The Coalition strongly supports the development of a national plan for e-health. The best outcomes for the plan will only arise if it is developed through a consultative process and is supported by key stakeholders

  Cost:
  Both the governance and workforce reviews would cost **less than $1 million in 2009-10** and be completed in 6-9 months. The Public Awareness Program needs to be planned after the strategy and business case is defined.

- Ensure the State/Territory and Commonwealth regulatory environments allow for the development and uptake of personal health records. It is vital we ensure there are no regulatory barriers to the adoption and use of Personal Health Records (PHRs, ie. electronic health records that are held by or for a consumer, can be shared with the consumer's health care providers and which can have information collected by health care provider input to the electronic record).

Cost:
This is an inexpensive proposal which will yield substantial beneficial outcomes. The maximum cost would be **$1 million in 2009-10** for a national framework consultancy and there would be some internal governmental implementation costs depending on the final approach adopted.

- Fund the development of electronic medication management systems throughout the health system in order to reduce some of the most common mistakes in health care and save lives, as well as dollars (savings estimated at $4-7,000 per bed per year).

  The Australian health care system faces many challenges over the coming decades. A shortfall in trained staff, increased demands on service, fragmented communication, and an aging population are all factors that lead to a widening disparity between quality and care. Coordinated e-Health solutions can provide the tools necessary to instigate significant changes to health with the greatest return on investment. In particular an early focus on electronic medication management will address the rising costs of medication, prevent adverse drug events and enhance patient outcomes:
  - Adverse drug events in Australian Public Hospitals cost approximately $420 million in additional bed days in 2005-2006[1];
  - The estimated cost for residential aged care hospital admissions nationally for the year 1 July 2003 to 30 June 2004 was $714 million[2];
  - The Beach Study found one in ten patients presenting to a GP had an adverse drug event, and the largest subset was for the 65+ age group (30.7%)[3];
  - It is estimated that across Australia 140,000 hospital admissions per year are associated with problems with the use of medicines[4]; and
  - 78% of GPs were not directly informed that their patient had been admitted to hospital and 73% of GPs did not directly receive discharge summary information[5].

  After initial implementation costs, the introduction of medication management in public hospitals would have a dramatic effect on raising the level of safety and quality in our hospitals and health system and act as a saving measure by reducing expenditure arising from medical error and misadventure.

  As the technology is proven in this case, the much greater challenge is to manage the impact of the change on the existing processes and the people involved. For this reason an incremental approach is recommended through the Government providing seed funding to encourage faster uptake of this technology by the states.

[1] AIHW, Australian Hospitals Report 2005-2005- Special ADE Query, Jan 2008
[2] Australian Divisions of General Practice Submission to the Coalition of Australian Governments Sep 2005 – Revised Sep 2006
[3] Beach Study ADEs in general practice patients in Australia .Graeme C Miller, Helena C Britt and Lisa Valenti MJA 2006; 184 (7): 321-324
[4] Australian Council for Safety and Quality in Health Care. Second National Report on Patient Safety: Improving Medication Safety. Canberra: Commonwealth Department of Health; 2002.
[5] A quality use of medicines program for continuity of care in therapeutics from hospital to community. MJA 2002;177: 32–34 Mant A et al

Any system to be installed under the program should be required to:

- Provide both electronic prescribing and administration of medications;
- Have the capacity to deliver decision support at all phases of the medication management process;
- Export fully atomised data for electronic discharge summaries; and
- Be compliant with evolving standards.

For the least risk and most benefit, governance of this infrastructure should be overseen by, or at least intimately involve the professional and/or industry associations associated with the healthcare domains being serviced.

Cost:
For implementation in every public hospital this project would cost $70-$100 million per annum ongoing plus recurrent costs and funding for change management. The cost includes hardware which can also be used for many other purposes (such as clinical guideline tools and pathology results).

The full introduction of electronic medication management throughout the health system would reduce some of the most common mistakes in health care and would save lives, as well as dollars (estimated at $4-7,000 per bed per year)[6].

4. **Oral and Dental Health**

Oral health is a vital component of overall health and well-being. Dental problems affect people's ability to eat (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. Yet gum disease and dental caries account for two of the top five main public health issues in Australia. Dental care is one of a few elements of public healthcare that is not covered by the Australian Health Care Agreements.

Almost half a million people are on waiting lists for public dental treatment, with an average waiting time of 27 months. It makes no health 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.

[6] AIHW: Australian Hospital Statistics 1998-99 to 2005-06

This crisis is reflected in:

- Over 400,000 adult concession card holders having teeth extracted in any 12 month period;
- Over 17,000 children aged 0-9 years admitted to hospital for dental treatment under general anaesthetic in 2003/04 — 350% more than in 1993/94; and
- Over 20% of people in residential aged care facilities in pain or discomfort from untreated dental conditions.

The AHHA recommends that the Australian Government:

- Establishes a National Oral Health Leadership Taskforce that will have responsibility for:
    - advising on the scope and implementation (including appropriate jurisdictional flexibility) of the Commonwealth Dental Health Program (CDHP) and Medicare Teen Dental Plan;
    - national workforce planning and coordination (including training); and
    - integration with the National Health and Hospitals Reform Commission.

    Cost:
    The estimated cost of forming and operating a National Oral Health Leadership Taskforce with an Advisory Body of six people and a research and support team of four is **$970,000 per annum ($2.91m over 3 years)**.

- Funds the evaluation of its oral health programs – in particular the Medicare Teen Dental Plan, the Medicare Chronic Disease Dental Program and the Commonwealth Dental Health Program. This could be achieved at relatively low cost using pre-existing systems and data collection mechanisms. For example, the incorporation of pre-existing dental item numbers in the Teen Dental Plan (already in use by public and private dental services) will provide the capacity to assess utilisation and outcomes. Failure to introduce evaluation strategies during early stages of the programs will result in limited or no capacity to monitor and assess the value/impact of the programs. Increased effort should also be invested in bringing more consistency to cross-jurisdictional reporting.

    Cost:
    The estimated cost of funding the evaluation of national oral health programs is **$600,000 in 2009-10 and $100,000 recurrent annual funding**.

- Commits ongoing funding to the Australian Research Centre for Population Oral Health to undertake an oral health survey every five years alternating between adults and children (based on an agreement with the states and territories to provide in-kind (staffing) or financial support and to enable the Centre to critically analyse and report on dental programs (see above) with improved national consistency.

    Cost:
    The cost of undertaking a five-year oral health survey is **$4 million**.

5. Service integration

Health service integration is essentially about the relationships between the parts of the health system. These relationships may be between service agencies, programs, or levels of Government. A well integrated health system is not one without boundaries, but one where the boundaries enhance service quality and efficiency. Poor integration can distort the allocation of resources, lead to inefficient practices, and work against best practice care and continuity of care.

A key challenge for the health system is how to achieve better integration across all types of care. A further challenge is to achieve the best balance of investment across these care types. This is particularly the case given the current lack of national focus on sub-acute care at the same time as there is increasing investment in both acute and transition care.

The AHHA recommends that the Australian Government:

- Undertakes a national and systematic analysis of the plethora of existing trials, studies and programs to identify best practice service integration and primary/community health care models which are cost effective, scaleable and transportable across jurisdictions.

  Cost:

  The AHHA recommends outsourcing the research project to an appropriate university or organisation over a 1-year period to provide recommendations and costing, estimated to be **$690,000 in 2009-10**.

- Undertakes a joint Governmental review of state/territory community health services with a view to ensuring that all Australians have access to prevention, early identification and early intervention services.

  Cost:

  The AHHA recommends outsourcing the research project to an appropriate university or organisation over a 1-year period to provide recommendations and costing, estimated to be **$870,000 in 2009-10**.

- Develops a national rehabilitation strategy that will include national workforce planning, national service planning standards, a rehabilitation integration strategy and a clear commitment from all levels of Government to provide active rehabilitation services to all patients who have the capacity to become more functionally independent.

  Cost:

  The AHHA recommends outsourcing a research project to an appropriate university or organisation over a 1-year period to provide recommendations and costing, estimated to be **$690,000 in 2009-10**.

- Funds, jointly with the state/territory governments, a program that supports extended hours of community services where these services support early discharge from hospital.

  Cost:

  Taking into account the number of community health services in Australia, the fact that Divisions of General Practice should be ensuring after hours GP services within their existing funding and the recommendation for cost-sharing with states/territories, the estimated cost per annum for the Australian Government is **$10 million**. This initiative is expected to result in savings from reduced presentations to hospital emergency departments.

- Funds the establishment of a national taskforce of clinicians, experts and consumers to assess existing electronic clinical practice guideline systems, including the UK's Map of Medicine*, for adaptation to the Australian healthcare environment with the view of implementing a system of localizable electronic clinical practice guidelines, in conjunction with states/territories, throughout the public health system. The system-wide adoption of known best practice within health care would also significantly improve quality and reduce preventable errors. Clinical Practice Guidelines provide clinicians with the best available evidence on treatment for specific conditions. Incorporating these guidelines into standard hospital and health service practices and making them available electronically will ensure that consistently high quality care is provided to all patients.

  *In summary, the Map of Medicine ©:

  - Is an evidence-based benchmark for clinical processes that supports the configuration of services, local commissioning and clinical practice across all care settings;
  - Addresses clinical governance by providing a national benchmark for clinical guidelines while allowing the development and sharing of local guidelines and care pathways;
  - Provides content which is a distillation of recognised international sources of clinical evidence, designed by clinicians;
  - Can be integrated with electronic medication management systems and other local healthcare IT applications; and
  - Includes software tools to facilitate localization of the content at a national and local level promoting usability and adoption.

  Cost:

  It is estimated that implementation of an electronic clinical practice guideline system would cost **$1.7 million per annum** [minimum five year term] for fully serviced Australianised web service; this cost includes initial core service training (train the trainers model). Additional costs may include local hosting and implementation requiring web-access and related hardware (clinical guidelines tools should not require extra hardware or network facilities if hardware has been installed for other clinical functions such as electronic medication management systems).