Submission

Australian Healthcare & Hospitals Association

Federal Budget 2010-2011

29 January 2010

1. Evaluation and expansion of rural multi-purpose services

During 2009 the AHHA in partnership with the Australian College of Health Service Executives (ACHSE) established a policy development group focussing specifically on rural multi-purpose services (MPS). A key finding of their Issues Paper (attached) is that there is no coordinated view or application of the current MPS model, nor understanding of how it will progress into the future. There are no coordinated data on the models and outcomes of MPS across Australia which severely hinders the prospect of assessing the effectiveness of the model as a mechanism for delivering integrated healthcare services in rural areas. Anecdotally, several MPS are known to function extremely well while others do less well.

Presently there are at least 126 multi-purpose services operating across Australia, some of which have been using the model since its inception in 1991. A number of states are expanding the communities in which the MPS model will be applied. A national evaluation of the current model will enable development of a standard evaluation framework that can be applied more consistently on an ongoing basis by service providers.

The MPS model can be viewed as a long-term trial of a number of recommendations put forward by the National Health and Hospitals Reform Commission in 2009, including fund pooling and integrated healthcare across primary, community and acute settings. A full evaluation of MPS would identify and endorse critical success factors to enhance existing services and expand the program across more sites.

The evaluation would establish the evidence base for the targeted expansion of MPS as recommended by the NHHRC, and will be posited in the context of proposed local and national governance and financing reforms. The methodology would include detailed collection and analysis of data from every MPS in operation and site visits to a selection of MPSs representative of the differences across and within jurisdictions.

The AHHA recommends that the Australian Government

- Fund a national evaluation of the current MPS model, identifying differences across jurisdictions in governance and application, critical success factors and how to achieve national consistency in accreditation, reporting and outcomes. A key outcome will be the development of a standard evaluation and data collection framework for MPSs.

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), is **$300,000 in 2010-11 only**. The research would be completed by the end of the 2010-11 financial year after which funds would need to be committed based on the recommendations for enhancement and possible expansion of the program.

2. Reducing disparities in hospital care and interventions for Indigenous people with acute coronary syndromes

In 2009 the Australian Healthcare and Hospitals Association (AHHA) and the Heart Foundation began work with other stakeholders to develop a suite of evidence-based actions that can reduce disparities in hospital intervention rates for Indigenous people with acute coronary syndromes.

Aboriginal and Torres Strait Islander people experience higher rates of death and illness from cardiovascular disease (CVD) than other Australians. Age-adjusted CVD death rates for Indigenous people are about three times that of the rest of the population[1]. Compared with other Australians, Indigenous people have three times the rate of major coronary events, such as heart attack, and 1.4 times the out-of-hospital death rate from coronary heart disease.

Disturbingly, when in hospital, Indigenous Australians have:

- More than twice the in-hospital CHD death rate
- A 40% lower rate of being investigated by angiography
- A 40% lower rate of coronary angioplasty or stent procedures
- A 20% lower rate of coronary bypass surgery[2].

A range of new policy proposals are needed that will collectively help to increase the life expectancy of Indigenous Australians and improve quality of life. These programs need to address significant issues facing Indigenous Australians including lack of access to important heart, stroke and vascular disease pharmaceuticals, lack of availability of, and access to cardiac rehabilitation programs, rates of rheumatic fever among the world's highest, and inadequate funding for Indigenous nutrition and tobacco control programs.

The AHHA and Heart Foundation specifically call for substantial funding attached to existing COAG *Close the Gap* commitments to address the differential treatment of acute coronary syndromes in hospitals for Indigenous Australians. We call for dedicated funding to:

1. Address the low levels of hospital interventions for Indigenous patients with heart disease; and
2. Build the capacity and capabilities of Aboriginal Community Controlled Health Services to provide cardiac rehabilitation services to Indigenous people.

Targeted initiatives

The AHHA and Heart Foundation recommend the following strategies and programs to achieve these objectives, many of which can be led by the Commonwealth and addressed jointly through COAG and/or the Australian Health Ministers Conference:

Knowing what happens to Indigenous people with CVD

- Develop agreed performance indicators for in-hospital CVD interventions for Indigenous patients in collaboration with the states and territories, based on existing data compiled by the Australian Institute of Health and Welfare
- Develop a national register for Indigenous people with cardiovascular diseases at all stages of severity
    - As a matter of urgency, improve the quality and consistency of monitoring and reporting arrangements for in-hospital interventions for Indigenous patients in every state and territory

[1] Australian Institute of Health and Welfare (AIHW) (2004). *Heart, stroke and vascular diseases – Australian Facts 2004*. AIHW Cat. No. CVD 27. Canberra: AIHW

[2] Australian Institute of Health and Welfare (2006) *Aboriginal and Torres Strait Islander people with coronary heart disease: Further perspectives on health status and treatment*, AIHW

- Set agreed targets to reduce and eliminate disparities over time – provide facilitation payments to assist jurisdictions in meeting targets and reward payments for those jurisdictions that achieve the targets, in line with the new health care financing arrangements determined by COAG in 2008

Ensuring cultural safety in a hospital environment

- Provide Indigenous cultural awareness training for all existing hospital staff
- Include Indigenous cultural awareness as a component of all clinical/professional health worker training and education
- Employ more Indigenous staff in hospitals with an initial focus on Indigenous Health Workers and liaison officers who have a background/understanding in cardiovascular health (extending over time to more Indigenous doctors, nurses and allied health professionals)
- Implement an education campaign to ensure that responding to Indigenous patients' needs is embraced as "everybody's business"

Making the health system more responsive to needs

- Modify the MBS and PBS to ensure primary and preventive health are more accessible for Indigenous people (may be assisted by the creation of the National Indigenous Health Agency and/or regional needs-based funding)
- Increase assistance for patient and family travel, including a broader range of support for family accommodation and specific Indigenous needs
- Fund the purchase of more on-site diagnostic and telecommunications equipment to keep people in their communities for as long as possible

Projected cost and timeline

Budgets have not been estimated for these projects, as some may be appended to projects/programs already underway, but it is anticipated that they will be of relatively minimal cost.

3. *Community engagement in health policy and planning 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 (physical and financial). The AHHA has been promoting greater community involvement in the planning, design, implementation and evaluation of healthcare that will result in more effective and responsive health policies and programs. This recommendation has been a feature of previous AHHA budget submissions that is still lacking commitment.

The AHHA recommends that the Australian Government

- Undertake 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.

Projected cost and timeline

The AHHA recommends outsourcing the research project to an appropriate university or organisation over a one-year period to provide recommendations and costing for a *National Consumer Engagement Strategy*. The estimated cost is **$1.05 million in 2010-11**.

4. E-health and health informatics

From being an early leader in its ability to manage and use health information, Australia is still falling behind comparative countries such as the UK, Canada and the US in terms of its infrastructure and financial commitment to investing in national standardisation that will ultimately save resources and lives. The Commonwealth 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 in previous budget submissions address this growing gap and are consistent with Australian Government and ALP policy and recommendations of the 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 recognises progress made in the past year towards national standardisation of regulatory frameworks and legislation to establish a Healthcare Identifiers Service (as recommended in the previous AHHA budget submission). However the Association laments further delays caused by deliberation of reform proposals that essentially support advice that has been before the Australian Government for some time and supported by all key stakeholders in the industry.

The AHHA recommends that the Australian Government

- 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

  Projected cost and timeline
  Development of a consensus plan would cost **less than $1 million in 2010-11** and be completed in 6-9 months. A public awareness program needs to be implemented after a strategy and business case is defined as part of the plan. This will be essential to ensure public acceptance and uptake of e-health services.

- Employ a Chief Health Informatician at the Commonwelath level, similar to the Chief Nursing and Midwifery Officer, who will help guide clinical input and uptake of e-health and the use of data to drive health system improvement, provide direct advice to the Government and Department of Health and Ageing, and be the public face of health informatics in Australia. This role may also be modelled on a similar appointment in the National Health Service (UK) for a national Clinical Director for Informatics. In part the role would be to promote more people to undertake training in health data analysis and informatics to ensure there are sufficient professionals capable of implementing and interpreting health data and information.

  Projected cost and timeline
  The Chief Health Informatician would be employed at a similar rate to the Chief Medical and Nursing Officers. Appointments would be for the same duration as these roles (or for a length otherwise determined by the Government).

- Recommit to funding a coordination project on 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 AHHA is concerned about reports that a tender to develop an e-prescribing and dispensing "benefits realisation and implementation plan" was recently cancelled. This kind of coordinating work in e-health is essential, and it is difficult to see how other reform plans could render such a project defunct.

After initial implementation costs, the introduction of medication management in public hospitals and other settings would have a dramatic effect on raising the level of safety and quality 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.

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.

Projected cost and timeline

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).

At a future date the savings from implementing electronic medication management solutions could be calculated based on robust measures established from the outset of national coordination of such technologies.

5. Making progress in oral and dental health

Over the past two years, the AHHA has been deeply concerned by the lack of progress in implementing and revising much-needed oral health programs that have been proposed or in operation since the 2007 Federal Election. The Association has been working relentlessly to develop solutions that fulfil the needs and expectations of all parties.

Oral health is a vital component of overall health and well-being. Dental problems affect people's ability to eat (affecting nutrition), socialise, find employment and fully participate in society (including links to productivity). If untreated, dental problems can develop into more serious health conditions requiring intensive treatment and sometimes hospitalisation. Recent cases, for example, have indicated implications for pregnant women who have oral disease and their babies. While these problems are widely recognised, gum disease and dental caries still 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 or by Medicare.

The AHHA understands that a proposal put forward by the National Health and Hospitals Reform Commission is currently under consideration that would provide dental care for all Australians. The Association's work over the past 12 months has been focussed on existing and proposed programs, including Denticare, while none of these options are necessarily ideal.

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.

The AHHA recommends that the Australian Government

- Immediately implement the Commonwealth Dental Health Program as a short-term step towards a more comprehensive dental program. This has had ongoing commitment of funds for the preceding two financial years, and has disappointingly had no expenditure on what would be a high-impact program. Implementation would rely on agreement to maintain expenditure on a revised form of the Medicare Chronic Disease Dental Program, but this may be in the form of an overall change in the CDHP to include targeted services to people with chronic conditions, rather than through Medicare.

  Projected cost and timeline
  As already budgeted, the cost for **2010-11 would be approximately $100 million** depending on whether chronic disease care is included (by extracting it from Medicare).

- Fund an evaluation of its only operational oral health program, the Medicare Teen Dental Plan. This would be possible at relatively low cost using pre-existing systems and data collection mechanisms (Medicare data).

  Projected cost and timeline
  The estimated cost of funding the evaluation of the Medicare Teen Dental Plan would be no more than **$100,000 in 2010-11.** The evaluation would take only 3-6 months and be completed by the end of 2010.