Senate Finance and Public Administration Committees

PO Box 6100

Parliament House

Canberra ACT 2600

Australia

11/02/2013

Senate Submission

I wish to make a few brief comments with respect to the Implementation of the Health Care Reforms, and with specific reference to the changes implemented in Queensland. Without prejudice these are my general observations. I make no reference to any particular person, board or entity nor by inference should my comments be seen to suggest that I have.

1/. Poor processes for the transition of Health care Expenditure to the Regions:

The implementation of Health Reform has been marred by a difficult transition process to the Statutory Board Structures of the Health and Hospital Service Boards (HHSB) in Queensland. This has lead to a great degree of uncertainty as to the role of the Governance Boards and the relationship that exists between the Board and the Executive. I do not believe that the Board Governance process is completely transparent and that there is a potential for community consultation and engagement to be secondary to the expressed desires of the Chair and the Executive. Further to this the evolution of working relationships with other care providers has been variable and inconsistent. Communication and Integration has been excellent in some regions and poor in others. I do not believe that there is a clear reporting requirement that includes demonstrable measures for consultation and integration.

2/. Cost pressures driving Health and Hospital Service Board Decisions:

There appears to be, at a Political Level, inconsistency around the devolution of funding from Federal to State Government in Queensland. This has been translated to repeated reductions in budgetary funds and a strong downward pressure on service delivery through the need to focus on the core business of acute care. Queensland Health has in the past been the key public health provider with community service obligations and roles in several aspects of primary care provision. The rapid withdrawal from several fields of community services e.g. School Health Nursing, from public health service provision and from niche services such as childhood immunisation has left significant service Gaps. These service Gaps have been only partially addressed through Medicare Locals only where the Medicare Local has funding to meet those needs. Federal Funding for Medicare Locals is significantly less than the State HHSB budgetary provisions and needs to be enhanced to allow the organizations to assess and fill the service gaps left by the devolution of control to Regional Public Service Providers...

3/. Staff Moral and effects on Service Delivery:

I have observed staff moral to be low since the transition to regional health funding. Workforce readjustment through redundancies, department reassignments and downgrades has left a significantly disaffected workforce with a sense of uncertainty with regards their roles. While some degree of realignment is necessary to achieve a regionally based solution I believe that the rationale and evidence base for appropriate workforce reduction has been second to cost pressures. Anecdotal stories from numerous sources speak of decisions made that are neither efficient nor sensible, with lost opportunities for workforce review e.g. changing staffing arrangements in theatres to allow increased through put. There is a confusing focus on MWAUs (Workforce activity units) over and above the rational study of workforce needs and recognition that variances occur across the regions. Further to this there has not been a translation of that workforce into Medicare Locals and the private sector e.g. General practice consequently increasing the workload on other Health Sectors. I am concerned that, in the pressure to achieve cost savings, standards and health service delivery targets are not being measured in an appropriate way as to demonstrate that community services obligations are maintained.

4/. Rural Health Service Delivery is at high risk of failure through perverse funding incentives:

With the devolution to Regions and the cost drivers imposed there is an increasing threat to Rural Health Service. The current funding models using Activity Based Funding provide a perverse incentive to transfer Patients from Rural Centres that rely on traditional Block Funding. It has to be accepted that the traditional models of care need to be reviewed, with consideration given to flexible staffing levels; wider use of tele-health and remote supervision after-hours, collocated primary care and aged care in small Rural Hospitals. With over 80 Queensland Rural Hospitals facing the potential threat of closure due to low activity levels and high staffing levels it is critical that a state wide sustainable solution is found. Part of the solution will require a thorough analysis of community need, close consultation and partnership between the HHSB, Medicare Locals, Workforce agencies, Emergency Services and other stakeholders to produce an acceptable measure of safety for Rural People. At present the cost drivers are placing these rural hospitals and consequently rural communities in line for extinction. In the context of regional health service delivery there is an even greater need for the system manager to define a level of Community Service Obligation that will protect Rural Communities. The HHSB should be assisted in developing appropriate models that ensure that all Australians can expect a consistent standard of care regardless of their physical.

5/. Health Care reform has been inconsistent, patchy and not inclusive of the whole health sector:

With the devolution to regional control there has been a failed opportunity to bring the whole of the health care community together and empower providers to synergize and enhance opportunities for quality health care. I note that the Emergency and Retrieval services stand outside the purview of the HHSB, with the system manager abandoning committees overseeing quality and safety at a state-wide level in an expectation that the Regions will take ownership. The patient journey across HHSB boundaries is confounded by silo like funding concerns, with potential for the poorer regional health service districts to be at risk, due lack of clarity around ensuring that funding follows the patient. It is not clear that the pricing unit for care in a major centre will be transferred to a regional unit where innovations such as specialist tele-health support for local team based care are implemented. Medicare locals, General Practice, NGOs and other providers in the Disability and

Aged care space remain dislocated from the Acute Care Sector in spite of the values espoused in the political drivers for Health reform.

6: A Person centred, community based model of care exists:

A person centred, patient focussed model called the "Medical Home"[i] places the patient at the centre of their care. Health reform is rebalanced to focus first on the immediate care providers and the community and access to acute care and hospital services as needed. It is this model that encompasses all of the health team, rather than a focus on technology and expensive care, waiting lists and operative intervention as the benchmarks for quality in health care delivery. The HHSB, Medicare locals and other providers should be linked through funding drivers that ensure cost effective partnerships rather than the current retreat to silo based, protectionism and role definition based on popularist perceptions.

In summary, I believe that health reform is moving in the right direction. It is my opinion that the primary care sector is where reform is needed. The weighting towards the acute care sector need to be bought into line with community expectations, and recognition that primary prevention, attention to the social determinants of health, and innovation in health care delivery in the home has the potential to deliver cost savings to the health system while improving the quality and safety of the Australian Health care System The current perverse incentives weighted towards cost containment, the inconsistencies in Federal Funding for Sate Service provision and the Political reinterpretations of that are a significant barrier to realizing the potential of Health Reform.

Yours Sincerely

Dr Ewen McPhee

MB.BS; FRACGP; FACRRM; DRANZCOG; GCertAVMed; DipPDerm; MAICD

General Practitioner and procedure GP Obstetrician

---

[i] Home, A. C. (n.d.). *The Medical Home*. Retrieved February 13, 2013, from The Medical Home: http://medicalhome.org.au/